

December, 1954

Medical Economics



How to Buy
Or Sell a Practice

Also in this issue:

'Medic' Does Job for M.D.s • What's Happening to
Malpractice Rates • Checklist of Tax Deductions

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hyperacidity is neutralized • cellular repair
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(1) Johnston, R. L.: J. Ind. St. Med. Assn. 46:849, 1953

(2) McHardy, G. and Browne, D.: Soc. Med. J. 45:1139, 1952



Kolantyl Gel

RE INFORMATION

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Magnesium Oxide	200 mg.
Sodium Lauryl Sulfate . . .	25 mg.
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December, 1954

Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS

How to Sell a Practice (or buy one) 97

Every year, several thousand doctors decide to relocate or retire. Their practices are usually worth more than the value of the tangible assets. But how do you price intangibles? Here's the full story of a typical practice sale

Things to Know About Investment Funds 107

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This doctor thinks a picture is worth a thousand words. His film of the birth process may well prove he's right

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Published monthly and copyrighted, 1954, by Medical Economics, Inc., 210 Orchard St., East Rutherford, N.J. PRICE: 50 cents a copy, \$5 a year (Canada and foreign, \$6). Acceptance authorized under Section 34.64, PL&R. CIRCULATION: 134,000 physicians and residents. PICTURE CREDITS (left to right, top to bottom): cover, 97, Robert Guidi; 120-121, Paul Seyler, M.D.; 128-131, N.B.C. CARTOONS: 99, Jerry McGrew; 103, Robert M. Vredenburg; 115, Carl Thomas; 118, Bill Yates; 123, John Billingsley; 134, Joe E. Buresch; 137, 205, Jack Schade; 146, Scott Taber; 167, William Boserman; 207, Al Kaufman; 233, Dan Danglo.

Panorama

V.A. plans no new hospi-

tals • Survey of delinquent bills unearths few deadbeats • Supreme Court upholds doctor draft • More psychiatric resident programs urged • Administration to push reinsurance again

Independent Plans Boom

While virtually all health insurance plans are registering gains these days, perhaps the fastest growing of all are the independent plans—those not associated with Blue Cross, Blue Shield, or insurance companies. Here, for example, are a couple of significant statistics, gleaned from a recent study by the Social Security Administration:

¶ In just four years—between 1949 and 1953—enrollment in the independent health plans doubled. Total enrollment at the start of this year: 9 million.

¶ During approximately the same period, union health plans alone quadrupled in number; and their membership increased from half a million to nearly 3 million.

Military Scholarships

The word around Washington now is that the doctor-draft, which expires July 1, will be allowed to die a natural death. Defense Depart-

ment officials have already come up with a new plan for supplementing the regular draft and for keeping the military services supplied with doctors.

Their proposal is being readied for the coming session of Congress. It calls for the Federal Government to grant medical (and dental) scholarships to qualified students. Upon graduation from the professional school of their choice, these men would then be required to put in one year of military service for each year of scholarship aid received. Minimum tour of active duty: three years.

Tax-Favored Pensions

As the result of a precedent-setting decision from a U.S. Court of Appeals, physicians practicing in groups may soon be permitted to set up tax-favored pension plans. The case on which the court ruled involved a plan adopted some years ago by a group in Missoula, Mont.:

The Western Montana Clinic,

headed by Dr. Arthur R. Kintner, set up a fund designed to take advantage of certain Federal income tax benefits granted to *employee* retirement plans. Under the provisions governing such plans, the employer can deduct his contributions to the pension fund from his gross taxable income; employees may defer payment of taxes on such portion of their income as is reserved for the fund until benefits actually begin (by which time, presumably, they'll be in a lower income bracket); and the pension fund itself needn't pay taxes on income from its investments.

Under the Kintner plan, the clinic itself became the employer; the physicians and other staff members were considered employees. But the Government claimed that, since the clinic was a partnership, the physician-partners simply couldn't qualify as employees. And the Internal Revenue department pointed out that its code states specifically that any tax-favored pension plan must be for the sole benefit of employees.

In siding with the Montana doctors, the U.S. Court of Appeals in San Francisco made a point that may well affect doctors in group practice everywhere: Even though the clinic may be a partnership under *state* law (which forbids physicians to incorporate for the practice of medicine), its special features make it a corporation under *Federal* tax law. And, said the judges, if the clinic is considered a corporation, its

physicians become, in the broad sense, "employees"—and so may legally participate in a tax-favored employee pension plan.

The Government didn't immediately indicate whether it would ask the Supreme Court to upset this decision. So it remained to be seen whether the ruling would serve as a legal precedent for the whole country. It seemed possible, though, that the Kintner case might give many doctors the long-promised tax relief they need to build up their pension funds.

Such relief may also be on the way from another quarter: Undersecretary of the Treasury Marion B. Folsom has announced that the Administration is still mulling over the problem of the "retirement income of people not covered by pension plans." It's possible, he suggests, that the President may press for some such legislation as the Jenkins-Keogh bill during the coming session of Congress. That bill, you'll remember, is strongly supported by organized medicine, since it would permit self-employed persons to defer tax payment on such portion of their income as they put away into a restricted annuity plan.

Punish Venal Druggists

Pharmacists tempted to substitute counterfeit drugs for the ones prescribed are finding less and less opportunity to get away with it. Two more states have now cracked down

hard in an effort to stamp out this practice:

1. The Florida State Board of Pharmacy has temporarily suspended the licenses of three druggists accused of violating the state's anti-substitution laws and has put four others on probation. In addition, board action is pending on at least ten similar cases.

2. An Illinois circuit court has granted preliminary injunctions against four offending retail drug-stores in the Chicago area. Said the judge, in handing down his decision: "The druggist has no right at any time to substitute anything for what the doctor ordered. If we ever got to the point [where he did have this right], we would have no doctors; we would have druggists only."

Cash Savings Go Up

The average family under your care has cash savings equal to nearly 85 per cent of one year's income after taxes—it does, that is, if it accurately reflects the *national* average.

Actually, the American people "now have more cash savings salted away than ever before," says U.S. News & World Report. It estimates that we have an unprecedented \$207 billion in liquid assets today—which is an increase of some 16 per cent over our total cash savings four years ago.

What's more, says the publication, this amount includes only cash holdings, Government bonds, loan

association shares, and savings deposits. It doesn't take into account several billion dollars more in less readily convertible investments like life insurance policies, stocks, bonds, etc.

No New V.A. Hospitals?

Administrator of Veterans Affairs Harvey V. Higley insists it's high time to set the record straight. The V.A., he told a recent meeting of Federal hospital administrators in Chicago, has about reached the end of its postwar hospital building program—despite A.M.A. predictions to the contrary.

When its program is completed, said Higley, "the V.A. will have in operation a grand total . . . of 174 hospitals, with a constructed capacity of 128,342 beds." The A.M.A.'s published estimate that "another 148,000 beds—the equivalent . . . of 200 *more* hospitals, each with a capacity of 740 beds—will be needed by the V.A., at a cost of nearly \$3 billion, is an *intentional* misleading statement," charged the V.A. executive.

Characterizing himself as "the son of one physician and the father of another," Higley added that he was thoroughly weary of hearing "the charge of 'socialized medicine' . . . leveled at the V.A. program." Any such charge, he maintained, is likely to be based on ignorance of what the V.A. stands for. For example:

"Probably all of you . . . have seen in medical publications or in the public press statements that run something like this: 'The V.A. provides free, lifetime medical care for all of America's nearly 21 million veterans and their dependents—a group comprising 40 per cent of our national population.' Let us reduce this fiction to facts: The V.A. has never been authorized to provide medical care for *dependents* of veterans, and so far as I know there is not now, *nor has there ever been*, consideration by Congress of such a proposal."

Another Tax to Pay

Here's a reminder: Beginning January 1, your office cleaning woman—and any household employes to whom you pay cash wages of \$50 or more every three months—will come under the expanded Social Security law. This means that you (or your wife) must:

¶ Put up the money to pay a 2 per cent tax on all such wages.

¶ Withhold a like amount from each employe's pay checks (or pay it out of your own pocket).

¶ Mail the combined total to your local Director of Internal Revenue at the end of each quarter. The deadlines: April 30, July 31, Oct. 31, and Jan. 31.

Additional facts to remember about the new law:

1. If your maid sleeps in, her room and board won't count as cash

wages. But any cash (not tokens) you give her for carfare will count as wages.

2. If you neglect to pay the tax on time, you'll be liable for interest—as well as penalties—on the amount due.

Few Deadbeats Found

Who's to blame for delinquent accounts? More often than you may think, *you* are. At least that's what the findings of the Alameda-Contra Costa (Calif.) medical society indicate. The society recently studied the cases of some 1,500 patients who hadn't paid their doctor bills. It discovered that only about one delinquent debtor in ten could accurately be called a "deadbeat."

The responsibility for the rest could, as often as not, be laid at the doctor's own doorstep. The California medical society's survey showed, for example, that:

¶ Some 30 per cent of the delinquencies were directly traceable to poor business methods in the doctor's office. In many such cases, the bill had been incorrectly made out or sent to the wrong address. In many other cases, the doctor had neglected to institute a routine follow-up.

¶ Another 20 per cent of the delinquencies apparently developed because the doctor had made no financial arrangement with the patient before treatment. Such patients were frequently surprised by

PANORAMA

the size of the subsequent bill, which they then proceeded to ignore.

The Alameda-Contra Costa society noted that when doctors took steps to correct some of these failings, their collections increased by as much as 25 per cent.

Doctor Draft Upheld

With the Supreme Court's recent refusal to review the case of Dr. William R. Bertelsen, it becomes clear that any further efforts to challenge the constitutionality of the doctor draft are probably doomed to failure. Consider the Bertelsen story:

During the war, the Neponset, Ill., physician had received seven-

teen months of medical schooling under the Navy's V-12 program. After the war, he was put on inactive status until discharged in 1947; and he completed his medical training on his own. Then, in 1953, he was called up for active duty as a medical officer.

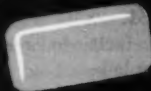
But Bertelsen felt that the Government had no right to command his services as a doctor. So he decided to make a test case of himself: He declined a commission and permitted himself to be drafted into the Army as a private.

Immediately thereafter, he moved for his release on the ground that the law under which he had been drafted was unconstitutional. In his appeal he charged that the doctor draft

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through prolonged direct
contact of aspirin.

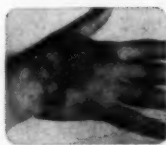
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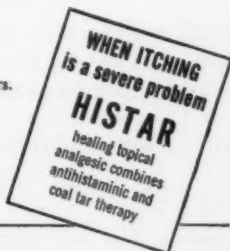
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discriminates against a particular occupational class in violation of the "due process" clause of the Fifth Amendment. And he argued further that the law simply caters to the Army's "misuse" of medical personnel "to care for large groups of civilians and civilian dependents of military personnel."

The Supreme Court's denial of a petition for review of his case spells bad news for another doctor who has questioned the Government's right to order him back to service. Like Bertelsen, Robert E. Farabaugh of Nutley, N.J., got part of his medical training at Uncle Sam's expense. But unlike his Illinois colleague, Dr. Farabaugh served a short hitch as an Army medical of-

ficer back in 1946. He didn't complete the required minimum of seventeen months' service, however; so, last summer, he was called up again.

Farabaugh, now 44 and the father of five children, apparently felt that his recall was unjust, for he refused to apply for a commission. But the Defense Department wouldn't take "no" for an answer; and he soon found himself a seaman-recruit in the Navy.

While not challenging the constitutionality of the doctor draft, he and his wife have been doing everything possible to obtain his release. They have claimed that it's impossible to keep the family together without the income from the doctor's practice. Mrs. Farabaugh maintain-

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References: 1. Antibiotics & Chemotherapy 2:55, 1952. 2. Scientific Exhibit, Norristown State Hospital. Data to be published.

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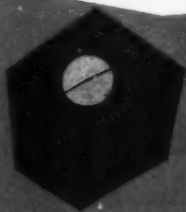
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moderate and severe
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- The more marked antihypertensive effect of Apresoline and its capacity to increase renal plasma flow.

Each tablet (scored) contains 0.3 mg. of Serpasil and 50 mg. of Apresoline hydrochloride.

C I B A
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12 000 000

ed, for instance, that she now had to depend on the generosity of her neighbors (the local Elks have chipped in \$100 to help plug the gap) and on Navy Relief.

As of last month, however, Navy officials evidently intended to hold Dr. Farabaugh until his time was up. They pointed out that the family didn't have to subsist on a seaman's allotment (\$136 a month); Dr. Farabaugh could have a commission any time he asked for it.

Pleads for Doctors' Sons

It's time the medical schools started giving "a break" to doctors' sons who apply for admission, says Dr. Irving J. Sands of Brooklyn, N.Y. He

deplores the fact that the children of physicians often have a hard time getting accepted—and sometimes even have to go to Europe to study.

After all, he argues in his county society's bulletin, the average doctor's son is "raised in an environment of self-sacrifice, altruism, idealism, and subordination of one's interests to those of the patient." As a result, such a boy is "more likely to possess [the necessary] qualifications than the boy raised in any other environment."

Dr. Sands suggests that "it would be well to investigate the entire subject of doctors' children studying medicine." Such a study, he feels, would "throw some light" on just why it is that "some medical schools

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The new strategy in angina pectoris is prevention, the new low-dose, long-acting drug—METAMINE. Most effective milligram for milligram, and better tolerated, METAMINE prevents attacks or greatly diminishes their number and severity. *Dosage:* 1 tablet (2 mg.) after each meal; 1-2 tablets at bedtime.

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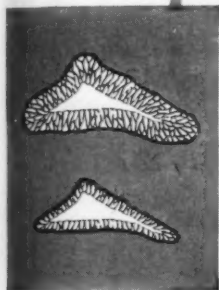
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Thus corticosteroid therapy causes depression of both the pituitary gland and the adrenal cortex.

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seem to bend backwards when interviewing sons of doctors."

In the meantime, he thinks it might be a good idea for a local medical society representative to serve on each institution's board of admissions. Chances are, says Dr. Sands, that an individual of this sort would at least be "quite well acquainted with the home environment of many of the doctors' children who apply..."

Save With Residents?

Budget-conscious hospital administrators are sometimes loath to add psychiatrists to their staffs because of the expense. But are they wise in this attitude? The value of psychia-

try "cannot be measured in dollars and cents," says Dr. Paul Sloane of Philadelphia (himself a psychiatrist).

In an editorial in Philadelphia Medicine, Dr. Sloane insists that his colleagues' services are absolutely invaluable to a general hospital, particularly "in the out-patient department and pediatric ward, in the treatment of psychosomatic illness, and in the study of the psychological reactions of the normal patient to his illness."

It's true, he admits, that psychiatry is expensive, since it "does not pay for itself." But he suggests at least a partial solution to this problem: Let the hospitals adopt more widespread and fuller psychiatric

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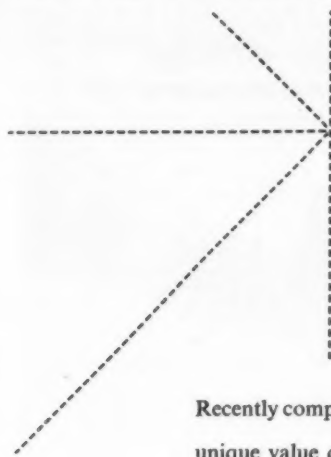
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"It is a significant fact that none of the . . . cases receiving iron as well as cobalt required additional iron therapy and that the haemoglobin levels of this group remained consistently and significantly higher than those in any other group after the age of 4 months."¹

"...there can be no doubt that the average hemoglobin values . . . are greater in the cobalt-iron (Roncovite) treated group."²

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"...the mothers of these anaemic infants frequently stated spontaneously that the children were much improved, with increased appetite and vigour. It seems possible, therefore, that even if anaemia in premature infants does not usually produce marked symptoms, there is a subclinical debility which becomes more evident in retrospect."³

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"There was no evidence of toxicity in any case under treatment: . . . There is nothing to suggest that cobalt in any way impairs the general progress or rate of weight gain in premature infants in the dosage employed."⁴

"The babies were closely observed daily for ill effects of the medication while at the premature unit and when they returned for check ups. None of them showed harmful effects despite the large doses. . . A few of the babies . . . have been followed for more than 100 days with no ill effects noted."⁵

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Each 0.6 cc. (10 drops) provides:

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Vitamin D250 units

DOSAGE:

One tablet after each meal and at bedtime.
0.6 cc. (10 drops) in water, milk, fruit or vegetable juice once daily for infants and children.

1. Coles, B. L., and James, U.: Arch. of Disease in Childhood 29:85 (1954).
2. Quilligan, J. J., Jr.: Texas State J. Med. 50:294 (May) 1954.

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PANORAMA

resident programs. Most residents, he points out, are "ready to forego large stipends if they can obtain good training."

'Guard Patient's Purse'

One way for medical men to retain the goodwill of their patients is to be more mindful of the cost of the procedures and treatments they prescribe, says surgeon James T. Priestley of Rochester, Minn., in the Archives of Surgery.

"We don't pay for [laboratory tests, blood transfusions, X-rays, drugs, etc.] ourselves," he says, "but it might be a good plan if we used them as if we did."

The blood transfusion is a good case in point, he adds; for, "through Red Cross and other blood banks, it has been made almost as easy for most surgeons to order a blood transfusion as an aspirin tablet . . . It appears to have become common practice in some areas to administer blood each time a certain operation is performed rather than to consider the needs of the individual patient and the amount of blood lost. To me this seems an unsound practice. This blood costs somebody something."

Reinsurance Reprise

The Administration means business with its reinsurance program; it intends to resubmit it to the upcoming Congress and to press for its adoption. The President himself has

IN COMBINATION DRUG THERAPY FOR

Advanced Hypertension

Rauwiloid® + Veriloid®

RAUWILOID 1 mg. and VERILOID 3 mg.
IN A SINGLE TABLET

For moderately severe to severe hypertension which does not respond adequately to Rauwiloid or other rauwolfia preparations alone. Makes Veriloid effective in better tolerated dosage.

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RAUWILOID 1 mg. and HEXAMETHONIUM CHLORIDE DIHYDRATE 250 mg. IN A SINGLE TABLET

For angiotensin-intractable, rapidly advancing hypertension; provides ganglionic blockade in simpler, more easily managed form. Smoother drug absorption—fewer side actions—prompt relief of symptoms.

Initial dosage, 1/2 tablet t.i.d. before meals and on retiring. In bottles of 100 slow-dissolving round tablets.

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PANORAMA

again repeated that he considers passage of his plan for Federal health reinsurance an absolute "must."

Mrs. Oveta Culp Hobby, whose job it will be to see the program through, has echoed the President's sentiments. The Secretary of Health, Education, and Welfare recently warned that if Congress again turns thumbs down on the proposal, a far more extreme plan may take its place.

"The American people are going to have protection against health risks" in one way or another, said Mrs. Hobby, sternly; reinsurance, she pointed out, will help them get such protection—and yet avoid the "regimented route."

A number of doctors have been skeptical of this argument. But there are indications that some are now coming around to the Administration point of view. Says an editorial in the Westchester (N.Y.) Medical Bulletin:

"In all candor we must admit that the medical profession was not the prime mover in the development of voluntary health insurance in this country . . . [But] most of us now concede that without [voluntary health insurance] some drastic form of compulsory government health insurance . . . would have been imposed on patients and physicians alike during the era of the New Deal . . .

"[Today,] those most familiar

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narily is excreted in large amounts in the urine. With REMANDEN, most of the penicillin is reabsorbed and recirculated.



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DIVISION OF MERCK & CO., INC.

Reference: 1. Am. J. Physiol. 166:639 (Sept.) 1953.

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NEOCYLATE WITH CORTISONE

A New Central Development, NEOCYLATE® with CORTISONE fulfills the recommendations of leading rheumatologists by providing, in convenient tablets, a potentiated salicylate formula (NEOCYLATE) combined with lower, safer doses of cortisone.¹⁻⁵ Full-scale antirheumatic effect is attained with minimal risk of undesirable complications. And—NEOCYLATE with CORTISONE is sodium-free.

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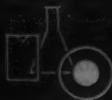
Ammonium Salicylate	0.25 Gm. (4 gr.)
Potassium Para-Aminobenzoate	0.32 Gm. (5 gr.)
Ascorbic Acid	20 mg. (1/3 gr.)
Cortisone Acetate	5 mg. (1/12 gr.)

RECOMMENDED DOSAGE: For acute cases, 8 to 10 Entabs daily in divided doses. For maintenance, 1 or 2 Entabs four times daily.

SUPPLIED: Bottles of 50 and 200 Entabs (enteric-coated tablets).

1. Committee of American Rheumatism Association: Primer on the Rheumatic Diseases, J.A.M.A. 152:323, 405, 1953. 2. Robinson, W. D., et al.: Tenth Rheumatism Review, Ann. Int. Med. 39:498, 1953. 3. Dry, T. J., et al.: Proc. Staff Meet., Mayo Clin. 21:497, 1946. 4. Wiesel, L. L., et al.: Brooklyn Hosp. J. 8:418, 1950. 5. Wiesel, L. L., and Barritt, A. S.: Am. J. M. Sc. 227:74, 1954.

Literature on request



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Secobarbital Sodium ½ gr.
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Phenobarbital ½ gr.

Bottles of 100 and 1000.

Usual tension-controlling dosage: 1 tablet ½ hr. before period of morning or afternoon tension. (For hypnotic effect without barbiturate hangover: 1 or 2 tablets ½ hr. before retiring.)



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PANORAMA

with the voluntary programs . . . generally agree that there are areas in . . . which [these programs] may forever remain weak . . . Unless some government assistance [of the nature of] the Eisenhower reinsurance program is developed, this weakness may become the Achilles' heel by which a small and dedicated group of social planners may be able to destroy . . . the voluntary programs and replace them with comprehensive 'socialized medicine.'

"The leaders of our profession turned 'thumbs down' on the President's plan presumably because they thought it tended toward 'socialized medicine'; the defeat of the plan by Congress, however, was more likely due to overwhelming opposition from groups who felt the Eisenhower plan was much too mild."

Concludes the editorial:

"We hope that the leaders of our profession on a national level will give careful thought to this urgent problem, so that when the President goes before Congress . . . with some modification of his original plan, he will be able to do so with the cooperation and whole-hearted endorsement of our profession.

"Mr. Eisenhower has repeatedly shown evidence of his genuine and high regard for our profession. There is little likelihood that the President will 'let down' the medical profession unless he finds himself 'let down' repeatedly by us." END

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END



FAT

on
the
outside

THIN

on
the
inside

The reduction of lean body mass . . . the withering away so commonly accepted with aging, represents an extensive loss of body protein.^{1,2} This condition may also occur with an increase in the fat content of the body, so that old people, although obese, still may hide a considerable reduction in lean body mass.³ Many times they look healthy and plump, but often are really suffering from reduction of lean body mass.

One excellent way to supplement the daily intake of protein is the low cost, easy to make, easy to take KNOX GELATINE DRINK. The *U.S.P.*, unflavored, all protein, sugarless Gelatine Drink is low in sodium, non-allergenic and is in a neutral pH range. Only 28 calories to every 7 gram envelope. KNOX GELATINE has been recommended by doctors for over 64 years as a dietary supplement and source for readily available protein, from pediatrics to geriatrics.

1. C. S. Davidson: Protein Metabolism With Particular Reference to Problems of Aging. Symposium on Problems of Gerontology, August 1964.
2. Brozek, J.: Changes of Body Composition in Men During Maturity and Their Nutritional Implications. Fed. Proc. 11:784 (1952).
3. Monroe, R. T.: Diseases in Old Age. Harvard University Press, Cambridge (1951).

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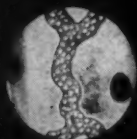
**and certain other
hemorrhagic conditions**

**"Many instances of hemorrhage
and thrombosis in the heart
and brain may be avoided if
adequate amounts of vitamin P
and C are provided."**

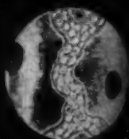


left Capillary loops of fingernail

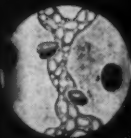
right Magnified capillary, showing
endothelial cells and
intercellular substance



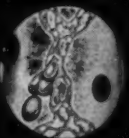
left Normal porosity of intercellular
cement permits passage of low
molecular weight proteins,
solutes and fatty acids.



right Increased porosity permits
passage of higher molecular
weight proteins and
excessive amounts of fluid.



left Greatly increased porosity
permitting passage of very
large protein molecules
and erythrocytes.



right Rupture of intercellular cement
results in capillary hemorrhage
as may occur in hypertension,
diabetes, purpura, etc.



Longitudinal sections showing passage of
erythrocytes through intercellular substance

C.V.P.

Each capsule, or teaspoonful (approx. 5 cc.)
of syrup, provides:

Citrus Flavonoid Compound	100 mg.
(whole natural soluble "vitamin P" complex)	
Ascorbic Acid (vitamin C)	100 mg.

C.V.P. STRENGTHENS fragile capillaries
by thickening the intercellular ground substance
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Each tablet contains:

Sodium diethylbarbiturate 45.0 mg.

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Sodium isobutylallylbarbiturate (Sandoptal) 25.0 mg.

Scopolamine hydrobromide 0.08 mg.

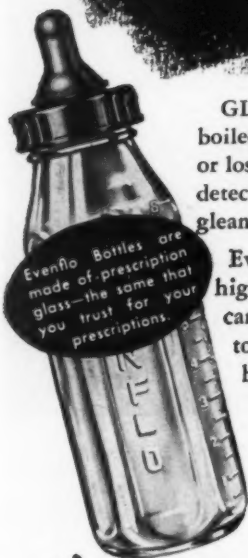
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1. Susinno, A. M., and Verdon, R. E.: J.A.M.A. 154:239 (Jan. 16) 1954.

2. Rottino, A.: Journal Lancet 71:237, 1951.

3. Pelner, L., and Waldman, S.: New York State J. Med. 52:1774 (July 15) 1952.

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RAUWIDRINE—a new experience in serenity and pleasant confidence for the depressed and melancholy, the dispirited and frustrated patient.

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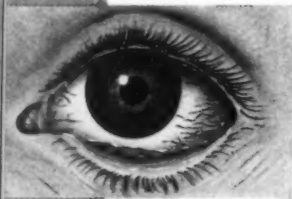
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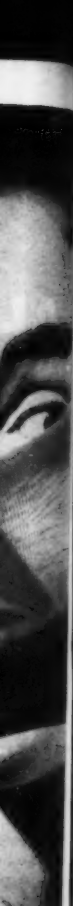


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BAUER & BLACK FASHIONED STOCKING knitted with rear-fashioning seam so that pressure is adjusted to leg contours, avoiding undesirable constriction. Pressure decreases gradually from ankle up, thus gently speeding circulation.

Shading indicates correct pressure pattern of Bauer & Black Elastic Stocking.





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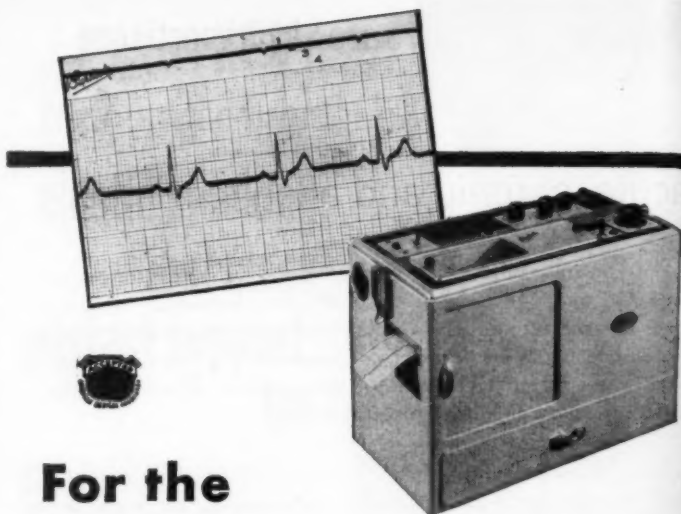
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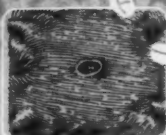
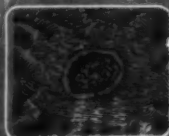
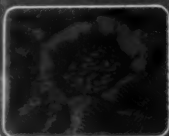
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a new drug dosage of homatropine methylbromide—
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Clinical studies at a recognized medical center
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Dose:

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MALCOTRAN 10 mg.
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As adjunctive therapy in peptic ulcer, by
suppressing excessive parasympathetic stimulation,
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Maltbie

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relieve the symptoms



A-P-CILLIN

...prevents and controls secondary infections
...while relieving "cold-like" symptoms

In a single convenient tablet, A-P-Cillin combines three widely prescribed therapeutic agents for control of acute upper respiratory infections and for relief of symptoms.

Each A-P-Cillin tablet contains:

1 APC—for analgesic and antipyretic action—to relieve systemic symptoms.

Acetylsalicylic acid 2½ gr.

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Phenyltoloxamine dihydrogen citrate 25 mg.

3 PENICILLIN—for prevention and control of secondary bacterial infections.

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For common acute upper respiratory infections, the usual adult dose is 2 tablets three times a day, continued for at least three days. Tablets should be taken at least one hour before or two hours after meals—supplied in bottles of 50 and 500 tablets.

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Sodium-free,
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for rheumatic diseases

ARTA

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SALICYLAMIDE

(non-irritating to gastric mucosa)

with

ORGANIC IODINE

(stimulates resorptive processes)

plus PABA and ASCORBIC ACID

Maintenance of high salicylate blood levels without undesirable side effects has long been a goal in the management of pain in rheumatoid arthritis, rheumatic fever, osteoarthritis, fibrositis and gout.

This goal has been achieved in *Artamide*. Through the use of salicylamide instead of one of the common salts or esters of salicylic acid, *Artamide* avoids gastric irritation. Coadministration of alkalinizing agents is therefore unnecessary. In addition, *Artamide* is completely free of sodium and potassium—an important consideration for patients requiring restricted intake of these elements.

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ARTAMIDE

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COMPOSITION: Each white, coated *Artamide* tablet contains Salicylamide (0.25 Gm.), PABA (0.25 Gm.), Ascorbic Acid (20.0 mg.) and *Organidin* (10 mg.).

SUPPLIED: Bottles of 100 and 500. **Dosage:** Two tablets three or four times daily; in acute rheumatic fever, may be increased to two tablets hourly.

Wampole LABORATORIES

Henry K. Wampole & Company, Inc., 440 Fairmount Avenue, Philadelphia 23, Pa.



RELIEVE AND PROTECT
TORTURED BABES
THE AMMORID[®] WAY

To relieve common skin irritations accompanied by itching, chafing, or burning, such as prickly heat, intertrigo, and diaper rash; promote rapid healing of excoriations and inhibit secondary infection; and provide an excellent after-bath dressing —

AMMORID
Dermatologic Ointment

Contains benzethonium chloride and zinc oxide, in a nongreasy lanolin base. Agreeably scented, easily removed with soap and water or soapless detergents. Supplied in 2-oz. tubes.

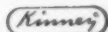
To protect against diaper rash—

AMMORID
Diaper Rinse

A unique product because it combines a special water-softening agent with methylbenzethonium chloride, which inhibits the formation of ammonia by checking the *Bacillus ammoniagenes*, organism responsible for releasing ammonia from urine. Diapers treated "the AMMORID way" are soft and will not chafe baby's sensitive skin.

Supplied in bottles of 240 Gm. of dry powder (enough for 360 diapers).

Samples and Literature on Request



KINNEY & COMPANY, INC.
Columbus, Indiana

Letters

Two views on specialty-board cer-

tification • In defense of psychiatrists' fees • How to liquidate a practice at retirement • Why physicians shouldn't run blood banks • Doctors with singular sidelines

No 'Pegged' Fees

Sms: I've just read with interest Dr. Edward J. McCormick's exhortation for average fee schedules applicable to "the vast majority of cases." His implication seems to be that the quality of medical care can be leveled and the price pegged. This is no more true of the physician's services than it was of beef under O.P.A.

In most cases, the doctor who devotes more time and attention to his individual patient feels, rightly, that he's justified in charging a higher fee . . . Most patients quickly smell out the few who overcharge.

J. L. Bordenave, M.D.
Geneva, Ill.

Young Doctors

Sms: I read with growing interest your recent report on young doctors and their goals . . . They all seem to be interested only in making more or easier money, obtaining shorter or more regular hours, acquiring more prestige, and so on, rather than in service to their fellow men.

You'd think that doctors, of all people, would have developed beyond such egocentric and narcissistic attitudes. If they haven't, their education, in the wider sense, has failed.

William Wolf, M.D.
New York, N.Y.

Sms: So fourth-year medical students now "feel that for the would-be specialist a temporary stretch in general practice is an impractical luxury"! It seems to me that a general practice experience of sufficient length should precede any specialization. Such was thought to be the necessity when I graduated in 1904; and I see no reason for a change today.

J. H. Schrup, M.D.
Dubuque, Iowa

Special Attention

Sms: The single, unadulterated cause of the trend toward "infectious specialitis" (described in your recent article, "Is the Family Doctor Obsolete?") is the lamentable

* A Most Potent Weapon
of Modern Medicine

Aureomycin^{*} Triple Sulfas

TABLETS LEDERLE

24-hour therapy against
gonorrhea • bacillary dysentery

each tablet contains

- AUREOMYCIN Chlorotetracycline 125 mg.
• Sulfadiazine 167 mg. • Sulfamerazine 167 mg.
• Sulfamethazine 167 mg.

AUREOMYCIN TRIPLE SULFAS is a
4-in-1 product, a potent therapeutic
weapon of modern medicine.

For gonorrhea, the recommended
dosage is 4 tablets: 2 tablets initially
followed by one tablet at 6-hour
intervals. Course may be repeated
if necessary.

For bacillary dysentery, dosage
should be based on patient's weight.
Average daily dose is 2 tablets 4
times daily.

Bottles of 12, 100 and 1,000.



•Trade Mark

LEDERLE LABORATORIES DIVISION

AMERICAN Cyanamid COMPANY

Pearl River, New York

creation of the specialty boards. Their existence now constitutes a Frankenstein monster that no physician dare openly discuss.

I speak as a diplomate of the American Board of Surgery.

M.D., Massachusetts

Sirs: I'm a board-certified specialist, and I'm getting sick and tired of sitting passively by, listening to the G.P.s beat the publicity drum for a return to medical mediocrity.

Sure, I wholeheartedly endorse the idea of the family physician. But it's antiquated and erroneous to suppose that "family physician" is synonymous with "G.P." There's only one man who can properly qualify for the job of family physician: the trained specialist in internal medicine.

One man who *can't* qualify is the impertinent little fellow who bursts forth fresh from a one-year internship and proclaims to the world that he is now prepared to deliver babies, perform surgery, fit glasses, mend fractures, and otherwise diagnose and treat all and sundry who are unfortunate enough to fall into his hands.

(Not infrequently, by the way, his charges would cause an honest and qualified specialist to blush for shame!)

M.D., Texas

Sirs: As the wife of a very conscientious general practitioner, I must protest the current assumption in

many medical circles that general practitioners lag behind their specialist colleagues in the practice of preventive medicine. The G.P.s practice *needful*, not *needless*, preventive medicine.

Must the specialists discredit their G.P. colleagues in order to increase their own practices? I'm beginning to wonder.

Doctor's Wife, New York

Tax on Insurance

Sirs: I'd like to clarify one statement in your September article on revisions in the Internal Revenue code. You said: "Under the new code, life insurance proceeds payable to your wife or child probably won't be included in your estate for tax purposes."

It isn't quite that simple: In order to take advantage of this tax benefit, the insured must agree to give up all incidents of ownership, his right to borrow on the policy or to surrender it for its cash value, his right to change the beneficiary, and his right to any reversionary interest worth more than 5 per cent of the face value of the policy.

James C. Rivers
Internal Revenue Service
Washington, D.C.

M.D. Insignia

Sirs: "Nuts to M.D. plates," says one of your readers, after being arrested for going through a red light.

For this he got peeved?

... Even President Eisenhower



A simple, easy way to relieve STUFFED-UP NOSE

Novahistine

Novahistine is a combination of



Each tablet is formulated with:
 (1) Phenylephrine hydrochloride 10 mg.
 (2) Chlorpheniramine maleate 4 mg.

Novahistine is an oral decongestant with oral dosage.

PITMAN-MOORE COMPANY
 DIVISION OF ELLIOTT LABORATORIES, INC., KENILWORTH, N.J.

LETTERS

should be given a ticket if he were to run through a red signal and thus endanger the lives of others.

Philip S. Ching, M.D.
Fresno, Calif.

Sirs: It shouldn't be *necessary* for doctors to display special automobile insignia to protect them from parking tickets when they're on emergency calls.

Most such calls are made either at a hospital or at a patient's home. In the former case, the hospital itself should provide plenty of private parking space for its medical staff, just as it provides enough operating-room space. Local doctors should insist that it do so.

As for house calls—well, probably only 1 per cent of these must be made in congested areas. If the doctor anticipates a parking problem, he should simply make the call by cab. He can then add the cost of the taxi to his bill with a clear conscience.

M. D., New Jersey

Psychiatrists' Fees

Sirs: One of your correspondents complains that psychiatric fees present one of the major problems of treatment for "any but the rich." I don't agree.

For several years I directed a mental hygiene center where patients could be seen for a nominal fee or, in some cases, without any fee at all. Yet appointments were broken more frequently, and for

consider

ILOTYCIN
(ERYTHROMYCIN, LILLY)

FIRST

...because
'Ilotycin' is
chemically
different

Virtually no gram-positive
pathogens are inherently re-
sistant—even when resist-
ant to other antibiotics.

Lilly

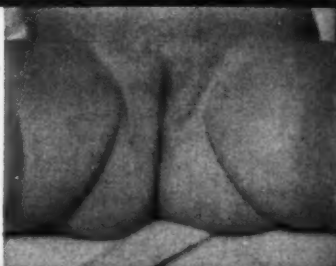
Available in tablets,
pediatric suspension,
and I.V. ampoules.

Gratifying Response in Diaper Rash



A typical case of diaper rash before treatment, characterized by excoriation and soreness.

After only one week of local applications with White's Vitamin A and D Ointment at each diaper change, the skin surface is normal. The soothing, protective and healing action of White's Vitamin A and D Ointment is the reason why it is used so extensively in this condition.



White's Vitamin A and D Ointment

—supplied in 1½-oz. tubes and 16-oz. jars for office use, 5-lb. jars for hospital use.

...and Equally Valuable in Severe Conditions

6 days after radical mastectomy, the defect is filled with postage-stamp grafts, and application of White's Vitamin A and D Ointment begins.



After only 14 days of therapy with White's Vitamin A and D Ointment, solid healing of the postage-stamp grafts has taken place.

Other Indications:

sunburn ... burns ...
traumatic lacerations ...
bedsores ... abrasions ...
chafing ... fissured nipples ...
indolent ulcers

White's Vitamin A and D Ointment presents the natural A and D vitamins in a pleasantly fragrant lanolin-petrolatum base. It does not stain the skin.

WHITE LABORATORIES, INC., KENILWORTH, N. J.

relieve
pain,
headache,
fever
promptly
and safely

APAMIDE®

(N-acetyl-p-aminophenol, Ames)

direct-acting
analgesic-antipyretic...
no toxic by-products...

APAMIDE-VES

TRADEMARK

(Buffered N-acetyl-p-aminophenol, Ames)

effervescent analgesic-
antipyretic... speeds relief
... assures fluid intake

APROMAL®

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sedative-analgesic-
antipyretic... calms patients
and relieves pain

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AMES COMPANY, INC.
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Ames Company of Canada, Ltd., Toronto

LETTERS

even less reason, than they are in private practice...

There is no doubt that patients use the excuse that high fees prevent them from going on with extended psychiatric care. But this is seldom the *real* reason.

J. M. Kenyon, M.D.
Toledo, Ohio

SIRS: Is the psychiatrist who charges his colleagues greedy, as the Norfolk (Mass.) Medical News editorial you quoted recently implies? The answer is, of course, no—not, at least, if he does psychotherapy.

Analytic psychotherapy takes an hour at each session and needs three to five sessions a week. So the psychiatrist has a rigid ceiling on the number of patients he can see. He cannot sandwich a patient in between two others, as the pediatrician or the nose-and-throat man does. For that reason, if he sees an M.D. patient without charge, he has to refuse another patient, thus taking money out of his own pocket.

M.D., Vermont

What's in a Name?

SIRS: So one of your readers thinks the title *Doctor* should be restricted to M.D.s! If he were better educated, he'd know that *doctor* means *teacher*—and has for centuries. It's only within the past few decades that barbers and healers have tried to dignify their trade by misappropriating a respectable title.

I suggest that M.D.s be the ones

"...BEST METHOD AVAILABLE..."

After giving 'Teldrin' *Spansule* capsules to 30 allergic patients over a 6 month period, Rogers¹ concluded:

"It is our belief that this drug in this form provides the best method available for using antihistamine medication."

'Teldrin' *Spansule* capsules are "the best method available" because they incorporate 3 distinct advantages:

1. They contain chlorphenpyridamine maleate, the widely prescribed, well-tolerated antihistamine.
2. They release this drug slowly, continuously, and uninterruptedly over a period of 8-10 hours, with a therapeutic effect lasting approximately 12 hours. Side effects are thus held to a minimum.
3. They provide maximum dosage convenience.

TELDRIN*
chlorphenpyridamine maleate
SPANSULE*
brand of sustained release capsules



S.K.F.'s widely acclaimed new

ANTIHISTAMINE

preparation

made only by

Smith, Kline & French Laboratories, Philadelphia 1

the originators of sustained release oral medication

1. Rogers, H. L.: Ann. Allergy 12:266 (May-June) 1954.

*T.M. Reg. U.S. Pat. Off. Patent Applied For

LETTERS

prohibited from using the title of doctor—until, at least, they can prove they know what it means.

Ph.D., Florida

Sirs: To claim that calling a Ph.D. "Doctor" creates "needless confusion" is to make a mountain out of an academic molehill . . . When the cry, "Is there a doctor in the house?" goes up, I've yet to hear of a Ph.D. or a chaplain answering it.

James A. Brussel, M.D.
Queens Village, N.Y.

Sirs: A youngster asked me how he could become a doctor quickly. I told him to take up tending bar. The practitioners of that healing art are called "Doc" too . . .

Hans Schroeder, M.D.
San Francisco, Calif.

Retiring Made Easy

Sirs: In a recent editorial, you suggested several ways to liquidate a practice. As a medical management man, I'd like to add one more to the list. It's based on an actual case that occurred in 1953.

Old Dr. A, retiring, said to young Dr. B, "I'll let all my patients know I'm giving up and recommend that they switch to you. For one year, you pay me half the net on those referrals. For another year, one-third. Then I'm out."

What has happened? Well, Dr. A got \$400 a month the first year, plus collected receivables. He's getting \$300 a month this year.

As for Dr. B, he has benefited too. He put no money down, and he didn't have to buy Dr. A's old equipment. He's not been stuck with any "pig in a poke." And he can rest assured that, according to available evidence, the plan is perfectly ethical.

Horace Cotton
Mastrom, Inc.
Charlotte, N.C.

Never the Twain?

Sirs: I think you're rubbing it in a little when you print pictures of such fabulous set-ups as Dr. Bassett's "dream" office. After all, your own surveys indicate that most of us can never afford such buildings.

Perhaps you should have two editions: one for the West Coast and Texas boys, and one for us here in the East. Your Eastern edition might feature ways to convert a linen closet into a three-man suite.

Lester Lando, M.D.
Monsey, N.Y.

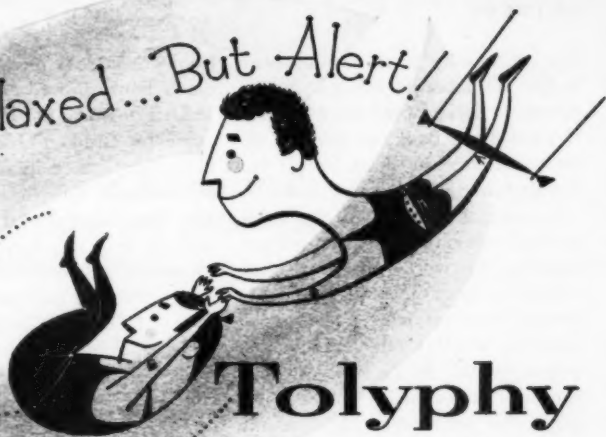
Community Blood Banks

Sirs: After reading through your recent—and extremely valuable—series of articles, may I express some of my ideas on the subject of community blood banks?

First, if a bank is a community enterprise, it cannot—and should not—be controlled by any single group. If a blood bank is run by the local medical society, or by any other single organization, it is *not* a community bank . . .

Secondly, to be most effective

Relaxed... But Alert!



Tolyphy

chimedic

Smooth and pain-free range of motion with complete muscle relaxation is accomplished by Tolyphy without loss of muscle tone or depressant effect on the central nervous system.

Tolyphy combines:

- Powerful spasmolytic action of Tolyspaz (Chimédic brand of mephenesin) with
 - Established neuromuscular effects of physostigmine and atropine
- to relieve pain, increase mobility, restore muscle strength and function.

Use Tolyphy Chimedic for safe, effective relaxation of muscle spasm or neuromuscular hyperirritability in a wide range of conditions such as

ARTHRITIS

FIBROSITIS

TORTICOLLIS

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MYOSITIS

TENDINITIS

For a clinical trial with your own patients, send for free samples and literature on Tolyphy and Tolyspaz.

Tolyspaz (Chimedic brand of Mephenesin) is especially designed to correct emotional stress and anxiety tension states, without "clouding consciousness."¹

J.A.M.A. 140:672
(June 25) 1949

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- ☐ Literature and samples of TOLYSPAZ

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LETTERS

the community bank should centralize all laboratory work on its premises. Here, at the King County Central Blood Bank, we perform all the cross-matching tests for all the hospitals in this area, carry on intensive research jointly with the local medical school, and do medicolegal investigative work. We feel that only very large hospitals could attempt these services; and it's debatable whether they could—or, rather, would—do the work as economically as we do it. Yet in many areas the community blood banks are thwarted by the hospitals in their efforts to render such services. Why? Even a cursory investigation gives the answer: money.

Finally, a physician may well

have good ideas on how to run a blood bank. But to argue that the M.D. is *qualified* to run it simply because he "studied" blood is rather like saying that he should be a sculptor because he studied anatomy. Blood banking today is a highly specialized field in which the average physician, or even the pathologist, can play only a perfunctory role.

J. Richard Czajkowski, PH.D.
Director, King County Central Blood Bank
Seattle, Wash.

'Free' Insurance Exams?

Sms: Why don't the insurance companies protect their investment by encouraging periodic check-ups of all policyholders? Why, for example, don't they give a premium return



agoral

Positive, gentle action assures complete elimination promptly, without griping or urgency.

WARNER-CHILCOTT

to run a
that the
mply be
is rather
a sculp-
natomy.
ghly spe-
average
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ki, Ph.D.
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At long last . . .

**The Comprehensive Antispasmodic
for both skeletal and associated
smooth muscle spasm**

REXPASMUS, a new combination of antispasmodics, plus a powerful analgesic—in single prescription form effectively reduces both skeletal and smooth muscle spasm, while affording more rapid release from pain.

Though skeletal muscle pain-spasm often engenders secondary smooth muscle spasm, no single antispasmodic preparation free of belladonna, barbiturates or amphetamine has heretofore been formulated to treat both types of spasm. In this respect, Expasmus is unique as it combines the smooth muscle relaxant, dibenzyl succinate and the skeletal muscle relaxant, mephenesin with the powerful analgesic, salicylamide to provide safe, fast-acting and comprehensive therapy.

Description: Each tablet of Expasmus contains dibenzyl succinate, 125 mg.; mephenesin, 250 mg.; salicylamide, 100 mg. Packed in bottles of 100 tablets, on your prescription only.

Indications and dosage: For relaxation of skeletal and associated smooth muscle spasm; relief of arthritic and low back pain; as a mild non-barbiturate sedative and relaxant in tension—Average dose, two tablets every four hours. Maximum daily dose, twelve tablets.

Samples Available to Physicians

MARTIN H. SMITH CO.

150 Lafayette St., New York 13, N. Y.

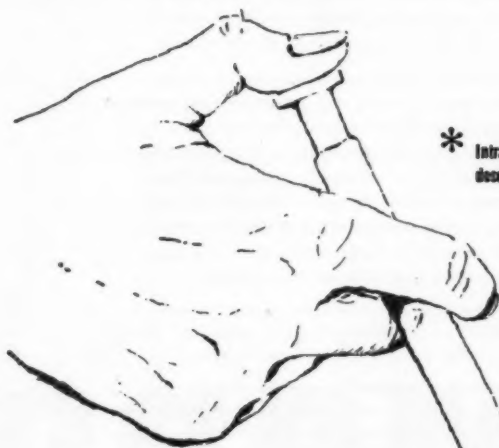
Manufacturers of ethical products for over half a century.

EXPASMUS

Parenzyme*

*A new, effective weapon
against acute
local inflammation*

Restores Local Circulation..



* Intramuscular trypsin, in very small doses ... 2.5 mg. (0.5 cc.)

THE NATIONAL DRUG COMPANY
Philadelphia 44, Pa.



PARENZYME (INTRAMUSCULAR trypsin) is based on an entirely new concept of *biological continuity* . . . in terms of clinical enzymology. In very small doses, it initiates physiologic mechanisms—and

- dramatically restores circulation
- expedites repair of tissue
- prevents tissue necrosis

Safe, compatible not an anticoagulant. No toxic reactions have been reported following administration of this new, intramuscular form of trypsin. PARENZYME therapy does not preclude the coadministration of other drugs. PARENZYME does *not* alter the clotting mechanism.

on.. with dramatic benefits in

phlebitis
thrombophlebitis
phlebothrombosis
traumatic wounds

iritis
iridocyclitis
chorioretinitis
varicose and diabetic leg ulcers

DOSAGE: *Therapeutic:* 2.5 mg. (0.5 cc.) of PARENZYME (INTRAMUSCULAR trypsin) injected deep intragluteally 1 to 4 times daily for 3 to 8 days. *When more intensive therapy seems indicated, small doses at more frequent intervals ensure better results than larger doses less often.*

MAINTENANCE: To stabilize response to therapy, or in recurrent or chronic diseases, 2.5 mg. (0.5 cc.) once or twice a week may be required for maximum benefit.

Vials of 5 cc. (5 mg./cc.: crystalline trypsin suspended in sesame oil), by prescription only.

Information on PARENZYME and on the research background of clinical enzymology will be mailed on request.

Parenzyme

Intramuscular trypsin



LETTERS

for an annual physical-exam report by a doctor of the policyholder's own choice?

M.D., Utah

Congressional Medal of Honor.

I even know of a doctor who married a banker's widow and lives on the profits.

M.D., Michigan

Singular Sidelines

SIRS: I was really tickled by your account of the psychiatrist who writes best-selling comics in his spare time. [See "The Man Who Creates Rex Morgan," October, 1954.] I wish you'd print more stories about doctors with sidelines.

There must be plenty of men to choose from, too. In this one state, I've heard of a physician who raises trout for sale, another who's the best farmer in his area, and a third who was a professional soldier before he became an M.D.—and who holds the

MEDICAL ECONOMICS *will be delighted to receive the name and address of any person (or organization) who might make an interesting subject for a profile or other write-up. Such a person may have a unique practice or secondary occupation. Or work in an unusual place. Or be a leader in medicine and an engaging personality as well. Or have an interesting patient (or patients). Or be noteworthy as a hobbyist, adventurer, collector, or sportsman.*

END

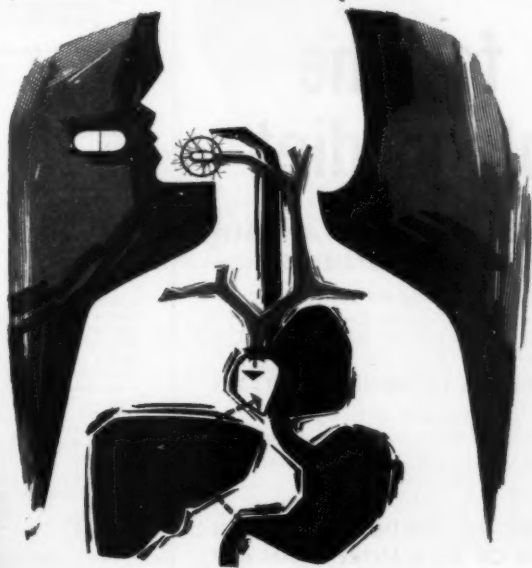
Millions prescribed yearly...

Handwritten on the prescription slip: "Rectal Medicone Supportiveness + xll Sig: As directed"

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The shortest route in oral androgen therapy—
by-passing the liver



With Metandren Linguets the transmucosal absorption of methyltestosterone permits direct passage into the bloodstream — by-passing the inactivating action of the liver and destruction by the gastric contents. *The response to Metandren Linguets approximates that of injected androgen.*

Metandren Linguets for buccal or sublingual administration provide methyltestosterone about twice as potent per milligram as unesterified testosterone.¹

Metandren Linguets also provide — economy for the patient • convenience for doctor and patient • freedom from fear of injection • easily adjusted, uniform dosages.

Metandren Linguets are supplied in tablets of 5 mg. (white, scored) and 10 mg. (yellow, scored); bottles of 30, 100 and 500.

METANDREN[®] LINGUETS[®]

1. ESCAMILLA, R. F., AND GORDON, G. S. J. CLIN. ENDOCRINOL. 10:248 (FEB.) 1950.

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LINGUETS[®] (TABLETS FOR MUCOSAL ABSORPTION CIBA)

C I B A

SUMMIT, N. J.

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A VITAMIN AND MINERAL RICH DIETARY SUPPLEMENT

for the bland diet

1

OVALTINE PROVIDES A WEALTH OF ESSENTIAL NUTRIENTS

And in a balanced relationship of protein, vitamins, minerals and other nutrients. See chart at right.

2

OVALTINE IS HIGHLY PALATABLE

The tempting flavor of this delicious food beverage adds zest to the bland diet. It is taken eagerly even by patients who dislike milk.

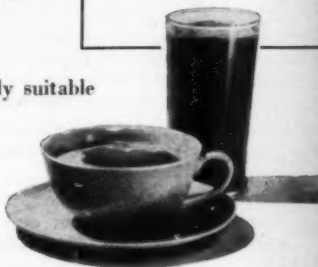
3

OVALTINE REDUCES CURD TENSION OF MILK MORE THAN 60%

This dietary supplement is an easily digested addition to the bland diet.

Thus Ovaltine made with milk is ideally suitable whenever a bland diet is required.

Ovaltine is equally delicious served hot or cold.



Ovaltine

The Wander Company
360 N. Michigan Ave., Chicago 1, Ill.

The World's Most Popular Fortified Food Beverage

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients
(Each serving made of 1/2 oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS

*CALCIUM.....	1.12 Gm.
*CHLORINE.....	900 mg.
*COBALT.....	0.006 mg.
*COPPER.....	0.7 mg.
*FLUORINE.....	0.5 mg.
*IODINE.....	0.7 mg.
*IRON.....	12 mg.
*MAGNESIUM.....	129 mg.
*MANGANESE.....	0.4 mg.
*PHOSPHORUS.....	940 mg.
*POTASSIUM.....	1300 mg.
*SODIUM.....	560 mg.
*ZINC.....	2.6 mg.

VITAMINS

*ASCORBIC ACID.....	37.0 mg.
*BIOTIN.....	0.03 mg.
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*FOLIC ACID.....	0.95 mg.
*NIACIN.....	6.7 mg.
*PANTOTHENIC ACID.....	3.0 mg.
*PYRIDOXINE.....	0.6 mg.
*RIBOFLAVIN.....	2.9 mg.
*THIAMINE.....	1.2 mg.
*VITAMIN A.....	3200 I.U.
*VITAMIN B12.....	0.905 mg.
*VITAMIN D.....	420 I.U.

*PROTEIN (biologically complete).....

32 Gm.

*CARBOHYDRATE.....

65 Gm.

*FAT.....

30 Gm.

*Nutrients for which daily dietary allowances are recommended by the

National Research Council.

coordinated action
against
pain / spasm

SALIMEPH-C

Trademark

in skeletal muscle
disorders



SALIMEPH-C, a new synergistic combination of mephenesin and salicylamide, successfully combats the interrelated pain and spasm of arthritis, myositis, bursitis, spondylitis, and low-back pain by providing:

SUSTAINED MUSCLE RELAXATION: in a new clinical study¹ of 200 unselected cases of arthritic and myositic conditions with associated pain and skeletal muscle spasm, **SALIMEPH-C** definitely gave effective relief from pain and spasm often after other forms of therapy including ACTH and Cortisone had failed.

MAXIMUM SAFE ANALGESIA: use of salicylamide in **SALIMEPH-C** provides desired analgesia at a lower drug level² and is better tolerated than acid-forming salicylates.^{3,4} Optimum vitamin C levels are assured by the addition of ascorbic acid.

REFERENCES: 1. Natenshon, A. L., Wisconsin M. J., in press. 2. Seeberg, V. P., et al.: J. Pharmacol. & Exper. Therap. 101:275, 1951. 3. Brodie, D. C., and Szekely, I. J.: J. Am. Pharm. A., Scient. Ed. 40:414, 1951. 4. Wegmann, T.: Schweiz. med. Wchnschr. 80:62, 1950.

*Trademark of Kremers-Urban Co.

Each tablet of **SALIMEPH-C** contains: salicylamide 250 mg., mephenesin 250 mg., and ascorbic acid 15 mg.

SUPPLIED: bottles of 100, 500, and 1000 tablets.



ethical pharmaceuticals since 1894
KREMERS-URBAN COMPANY
LABORATORIES IN MILWAUKEE

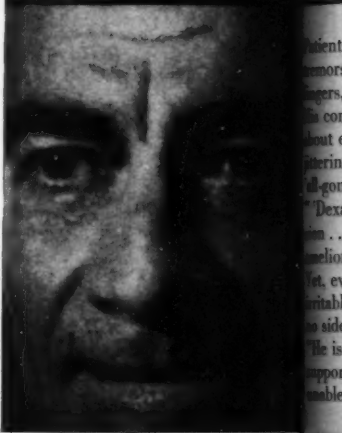
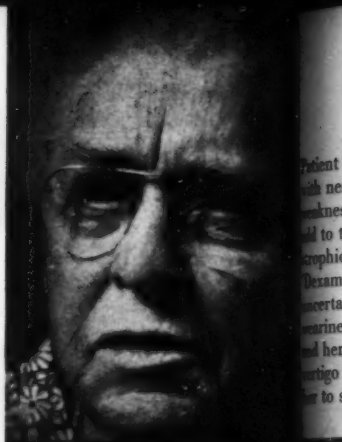
... a "confused" old lady

'Dexamyl' helped

... an extremely nervous man

(Photographs and excerpts of case histories from the files of a general practitioner.)

Remember: 'Dexamyl' is now available in the unique 'Spansule' capsule dosage form—to provide smooth, prolonged, uninterrupted mood-ameliorating effect for a period of 10-12 hours—with just one oral dose. 'Dexamyl' Spansule capsules are available in two strengths (see lower right, facing page).



Patient S. M. (80) was "plagued with nervousness, profound weakness, vertigo, and pain . . . added to this the untimely catastrophic death of a daughter." 'Dexamyl' relieved "her nervous uncertainty, her depressive weariness, her melancholia, and her tearfulness . . . also her vertigo . . . 'Dexamyl' helped her to smile again."

Patient L. H. (51) "had positive tremors of the eyelids, tongue, fingers, lips and voice . . . His complaints always centered about extreme nervousness, jitteriness, depression, and all-gone weakness". "Dexamyl" allayed inward tension . . . gave him a sensation of amelioration and comfort . . . Yet, even in this intensely irritable patient, there were no side effects . . . He is now able to work and support himself, which he was unable to do for several years."

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tablets—elixir—Spansule† capsules

relieves both anxiety

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'Dexamyl' provides the synergistic action of two mood-ameliorating components: 'Dexedrine' and amobarbital.

Tablets—each containing Dexedrine* Sulfate (dextro-amphetaminesulfate, S.K.F.), 5 mg.; amobarbital, ½ gr. (32 mg.).

Elixir—each teaspoonful (5 cc.) equivalent to one Tablet.

Dexamyl Spansule (No. 1)—each containing the equivalent of *two* tablets: 'Dexedrine' Sulfate, 10 mg.; amobarbital, 1 gr. (65 mg.).

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*K.M. Reg. U.S. Pat. Off.

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FOR BABIES

Easily Digested! Recognizing the importance of digestibility, Gerber's use only fully-ripe fruit for their new Strained Bananas for babies. Degree of ripeness is always uniform. A touch of tapioca is added for stability. 89% of the easily-digested carbohydrates are derived from the fully-ripe banana puree.

Highly palatable! Gerber's Strained Bananas contain a minimum of added sugar for palatability... a small amount of lemon juice to enhance flavor and protect appealing banana color.

Pleasant consistency! Extra-smooth texture makes Gerber's Strained Bananas particularly agreeable to infants.

NEW Strained Garden Vegetables

A palatable combination of peas, carrots and spinach provides a mild, pleasant new flavor... and increased nutrients.

Gerber's Strained Garden Vegetables blend these important "green and yellow" group vegetables... for exceptionally high vitamin-A value.

This new combination also supplies liberal amounts of iron... offers a good source of the increasingly important "trace minerals."

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in dermatologic conditions

... two new and potent

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(SQUIBB FLUOROHYDROCORTISONE ACETATE)

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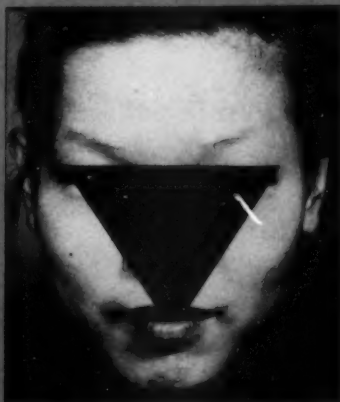
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*Condition before treatment
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*Condition twelve days
after treatment*

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in skin disorders — new

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Florinef 0.2 per cent appears to be therapeutically equivalent to 2.5 per cent hydrocortisone

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Florinef Ointment, 0.1 and 0.2 per cent, is supplied in 5 gram and 20 gram collapsible tubes. Florinef Lotion 0.1 and 0.2 per cent, is available in 15 cc. plastic squeeze bottles.



*Nine days after
Florinef Lotion 0.2 per cent
was applied to
left side of face*



*Nine days after
hydrocortisone lotion
0.2 per cent was applied
to right side of face*

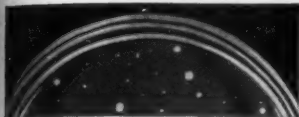
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With ordinary soap. Even after thorough washing, thousands of active bacteria remain on the skin.



With Dial soap. Daily use of Dial with Hexachlorophene eliminates up to 95% of resident skin bacteria.

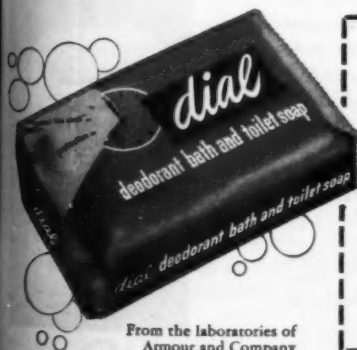
1. *Reduces chance of infection* following skin abrasions and scratches because Dial effectively reduces skin bacteria count.

3. *Protects infants' skin*, helps prevent impetigo, diaper and heat rash, raw buttocks; stops nursery odor of diapers, rubber pants.

2. *Stops perspiratory odor* by preventing bacterial decomposition of perspiration, known to be the chief cause of odor.

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You know, of course, the remarkable antiseptic qualities of Hexachlorophene soaps, as documented in recent literature. Dial was the first toilet soap to offer Hexachlorophene content to the public. You can safely recommend Dial. Under normal conditions it is non-toxic, non-irritating, non-sensitizing. Furthermore, Dial Soap is economical, and widely available to patients everywhere.



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This is a complete kit for Wintrobe hematocrit and sedimentation tests—with Dr. Best's Calculator for rapid and simple correction of Wintrobe Sedimentation rate.

With the kit comes a stainless steel syringe cannula, permitting use of the same syringe for taking of blood sample and for filling the Wintrobe tube.

The Physicians Outfit for the Wintrobe Blood Sedimentation Test provides all the apparatus necessary for performing these tests in a physician's office: Note: the ADAMS Safety-Head Centrifuge (CT-1002) is recommended for use with this test as fulfilling the centrifugal force requirements.

The complete kit contains:

- Best Calculator for Wintrobe Sedimentation Rate Corrected for VPRC (volume of packed red cells)
- Rack for three Wintrobe Tubes
- Wintrobe Hematocrit Tubes (3) with indelible graduations
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A-2448 Physicians Outfit for the Wintrobe Blood Sedimentation Test, including equipment listed above, complete with directions, each \$15.00

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WRITES OFF BED SORES AND BED CHAFE?



Positive Protection

by lubrication follows routine use of DERMASSAGE—
lotion type rub with germicidal hexachlorophene,
oxyquinoline and other therapeutic values.
DERMASSAGE enhances the benefits of massage and of
routine body rubs, reduces bed sores and bed chafe
to rare instances

TEMPORARY EASEMENT

with repeated drying out
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rapidly evaporating rubs,
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1000 CC. H₂O
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Due to the marked affinity
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immediately dispersed
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tends to remove the natural
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MATERNAL MORTALITY? Steadily declining.

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Have you adopted the skin care which
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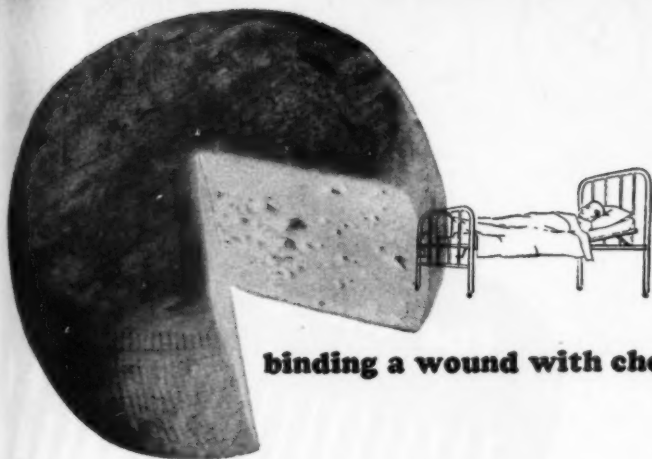
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Sample of DERMASSAGE.

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binding a wound with cheese

A wound is as strong as the connective tissue that holds it together...and the maximum strength of a wound is reached more rapidly when the diet contains liberal amounts of protein for growth of connective tissue.¹

Cheese, long recognized as an excellent and concentrated source of easily-digested milk protein, simultaneously provides generous amounts of calcium, phosphorus and other nutritionally important minerals and vitamins.

Cheese is likewise indicated for its high protein value in the geriatric diet² and whenever low tissue protein stores are suspected, not only in poorly healing wounds but also in patients with bed sores, chronic bullous diseases, atopic dermatitis, and senile pruritus.³

The wide variety of Borden cheeses lends itself to a diversified diet—from main dishes based upon popular Cheddar and Swiss or refreshing salads with soft Cottage or Cream cheese—to epicurean Camembert or Liederkanz Brand that add a tangy finish to the meal.

High palatability, pleasing texture and delicious flavor, characteristics of Borden cheeses, stimulate the appetite and contri-

bute to greater eating enjoyment for both the convalescent and other members of the family.

Manufacturers and distributors of BORDEN'S Instant Coffee • STARLAC non-fat dry milk • BORDEN'S Evaporated Milk • Fresh Milk • Ice Cream • Cheese • EAGLE BRAND Sweetened Condensed Milk • BREMIL powdered infant food • MULL-SOY hypoallergenic food • BIOLAC infant food • DRYCO infant food • KLIM powdered whole milk

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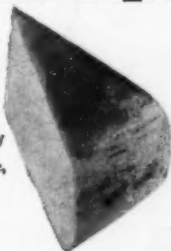
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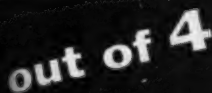
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who have
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For the scalp-scratchers, shoulder-brushers and comb-clutterers, there's welcome relief with SELSUN Sulfide Suspension.

Published reports on more than 400 cases¹⁻³ show that SELSUN completely controls seborrheic dermatitis in 81 to 87 per cent of all cases, and in 92 to 95 per cent of common dandruff cases. It keeps the scalp free of scales for one to four weeks—relieves itching and burning after only two or three applications.

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1. Slepian, A. H. (1952), Arch. Dermat. & Syph., 65:228, February.
2. Slinger, W. N., and Hubbard, D. M. (1951), *ibid.*, 64:41, July.
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Ril for the relief of hypertension

a pure, crystalline alkaloid
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'Sandril' produces a gradual and sustained reduction of blood pressure as well as a state of mental quietude and relaxation. In mild to moderate labile hypertension, 'Sandril' alone is usually adequate. In more severe, fixed hypertension, 'Sandril' is a valuable adjunct

to 'Provell Maleate' (Protoveratrine A and B Maleates, Lilly).

The emotion-calming effect of 'Sandril' is also beneficial in such conditions as anxiety states, nervousness, and menopause.

Supplied as 0.25-mg. scored tablets in bottles of 100 and 1,000.

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In the menopausal patient, the calming effect of 'Sandril' is greatly appreciated; estrogen therapy may be enhanced.

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the year 'round

to accelerate

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the pioneer external **cod liver oil** therapy

New impressive studies¹ again confirm the clinical value^{2,3} of Desitin Ointment to protect, soothe, facilitate healthy granulation, and speed healing even in stubborn skin conditions often resistant to other therapy.

in **wounds • burns • ulcers** (decubitus
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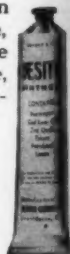
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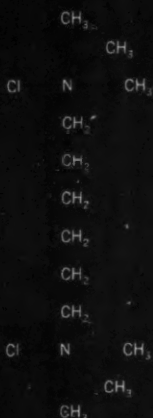
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"a perfect match"



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The potent autonomic ganglionic blocking action of Methium has now been augmented by the mild hypotensive and sedative properties of reserpine. A true synergistic combination, Methium with Reserpine produces "better hemodynamic stability than when either one is used alone."¹ In one series, more patients obtained adequate blood pressure reduction than from any single drug or combination of drugs previously reported.¹

Of special significance, a satisfactory response has been achieved with less than half the usual Methium dosage.² As a result, "the occurrence and intensity of physiologic side effects were markedly reduced and were minimal and of benign nature."²

Because of the potency of Methium, careful use is, nevertheless, required. Precautions are indicated in the presence of renal, cardiac or cerebral arterial insufficiency. Markedly impaired renal function is usually a contraindication.

Supplied: *Methium 125 with Reserpine* — scored tablets containing 125 mg. of Methium and 0.125 mg. of reserpine. *Methium 250 with Reserpine* — scored tablets containing 250 mg. of Methium and 0.125 mg. of reserpine.

1. Ford, R. V., and Moyer, J. H.: *Am. Heart J.* 46:754 (Nov.) 1953.
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Methium® with Reserpine

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Some of the very best people use

VI-PENTA

Pleasant orange-tasting Vi-Penta Drops supply required amounts of A, C, D and principal B-complex vitamins for people of growing importance.

Add to other liquids or give by the drop directly from the bottle.

In 15, 30, and 60-cc vials with calibrated dropper, *dated* to insure full potency.

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Editorials

The wrong way to build

a practice • Postscript on veterans' hospitals • The myth of medicine's 'bad press' • Electronic record cards • More practices are being sold • Atomic alert

Efficient Pricing

Too many doctors build their practices on the basis of high fees and low volume. They could earn just as much, and satisfy the public a lot more, if they aimed for the lowest prices and the greatest number of patients consistent with good medical care.

This is the conclusion any orthodox economist might reach if he were in close touch with the profession's business problems. But for doctors themselves to say as much—well, it's a mite *unorthodox*.

Nevertheless, we're saying it. And we're joined in this view by an increasing number of medical men. One of them, Dr. Thomas K. Callister of Salt Lake City, recently put the idea into these thoughtful words:

"Medicine, in its national as well as individual sense, is a business . . . And while medicine knows no direct competition for the consumer dollar, its failure to think in terms of cost has . . . endangered its survival as an independent entity.

"Medicine must accept, as any other business does, that its components are quality, price, and service; that its aim is to increase efficient operation; and that its over-all policy is to afford the public the most of the above components at the least cost commensurate with a satisfactory return."

But aren't we already operating pretty efficiently? Not if you listen to the public, Dr. Callister points out: The cry of the land is "Medical care costs too much!" This, despite the fact that our percentage share of the total consumer outlay hasn't gone up for the last twenty-five years.

"What this means," Dr. Callister observes, "is that the public . . . is dissatisfied with the *unit price* of medical care, not with its over-all cost." It's the individual fee that stirs up discontent—especially in surgical cases:

"Most persons outside the profession, and many within, consider it morally wrong—regardless of aptitudes and training required—for so indispensable a commodity as health

EDITORIALS

service to be disposed of at rates of \$100 or more an hour. Yet much of surgery (pre-operative and post-operative time considered) will exceed this on a cost basis.

"Quite conceivably," Dr. Callister concludes, "fees in general are too high. That is, they could be reduced without a consequent reduction in [the doctor's] net income..."

All this supports something we have long observed: The most successful doctors we know are not the highest-fee men. Instead, they put top emphasis on *efficient operation*.

They attract a great number of patients through their moderate charges. And they handle them successfully by delegating all possible routine to as many as three or four

well-trained aides. The secret of American enterprise is nothing more than this: higher production, lower unit prices.

Have you applied this principle in your own practice? If not, your patients may eventually find that they can get the same service for less money elsewhere. They're perhaps bound to, in view of the growing number of medical men who are moving toward more efficient pricing.

'Too Damned Bad!'

Last month we ventured an opinion that the large number of veterans with mental disorders, tuberculosis, and other long-term illnesses didn't

TABLETS

Remanden.

PENICILLIN WITH BENEMID®

extends the scope of penicillin therapy

LESS PENICILLIN WASTAGE—NO RENAL IMPAIRMENT

The 'Benemid' in REMANDEN "selectively and reversibly inhibits the transport mechanism responsible for the tubular secretion of the penicillins...It does not inhibit all tubular secretory systems."¹ Penicillin ordi-

narily is excreted in large amounts in the urine. With REMANDEN, most of the penicillin is reabsorbed and recirculated.



Philadelphia 1, Pa.

DIVISION OF MERCK & CO., INC.

Reference: 1. Am. J. Physiol. 166:639 (Sept.) 1953.

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B-D MULTIFIT[®] SYRINGES

When you use B-D MULTIFIT SYRINGES you get

ease and speed of assembly—less labor Tedious matching of parts is eliminated,

lower replacement costs Unbroken parts may be fitted to intact opposite parts—because every MULTIFIT plunger fits every MULTIFIT barrel.

reduced breakage Because it's molded, the MULTIFIT Syringe barrel is tougher—stronger—more resistant to breakage.

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sizes now available:

2 cc., 5 cc., and
10 cc.—LUER-LOK[®]
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Before Use of Riasol



After Use of Riasol

The worst cases of PSORIASIS



respond best to
RIASOL

In the clinical investigation of RIASOL, patients who had resisted all other treatments were selected. With these controls, the results with RIASOL are impressive:

Improvement of skin lesions, 76%
Complete clearing of skin, 38%
Great improvement of skin, 67%
Scaliness cleared or greatly improved, 71%.

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Recurrence of psoriasis, 19%.

Adverse effects with RIASOL, 0.

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RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

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Please send me professional literature and generous clinical package of RIASOL.

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RIASOL FOR PSORIASIS

XUM

EDITORIALS

necessarily justify the building of more and more V.A. hospitals. This month Palmer Hoyt, publisher of the Denver Post, adds a forceful postscript:

"The contention of veteran groups seems to be that such long-term illnesses among veterans must be the responsibility of Uncle Sam because alternative facilities are inadequate. If they are inadequate for *non-veterans*, that is apparently just too damned bad!

"If we haven't hospitals [enough] to absorb the demands imposed by society, it is no answer to siphon off some of the load by creating a special class of citizens and paying for them out of a different pocket . . . Whom do we think we are fooling? . . . V.A. hospital and medical care has cost \$4 billion since 1947. Can anyone be under the illusion that this represents 'cheap' hospital and medical care?"

We should "shrink our V.A. hospital program," Mr. Hoyt suggests, and put the money into more hospitals open to *all* the people. His proposed shrinkage won't appeal to organized veteranism. But it should appeal to some of our new national legislators. Weren't they recently elected to represent *all* the people, and not just veterans alone?

Magazine Medicine

There's been a lot of head-shaking lately over our profession's "bad press." A physician in Phoenix, Ariz.,

White's sulfathiazole gum



brings a high concentration of sulfathiazole directly to the site of oropharyngeal infection—producing the most prolonged, effective local antibacterial levels with virtually no systemic absorption.

Now—even more pleasing flavor and chewing texture.

3¼ grains of Sulfathiazole in pleasant chewing gum form.

White Laboratories, Inc., Kenilworth, N. J.

to forestall

resistance

Biosulfa

in everyday practice

PENICILLIN

still the antibiotic of first choice for common infections . . .

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to increase antibacterial range and reduce resistance . . .

Three strengths:

125M, 250M, 500M

Each tablet contains:

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125,000 (or 250,000 or 500,000)
units

Sulfadiazine 0.167 Gm.

Sulfamerazine 0.167 Gm.

Sulfamethazine 0.167 Gm.

Supplied:

Scored tablets in bottles of 50.

Biosulfa 125M also available
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EDITORIALS

was apparently thus influenced to write:

"The public has become intolerant of doctors and hospitals chiefly because of what they read in magazines . . ."

Far be it from us to debunk the power of the printed word. We think it only fair to point out, however, that the words printed about doctors and hospitals add up somewhat differently than you might be inclined to think.

Recently, for example, Robert M. Cunningham Jr. reviewed all such articles that had appeared in the nation's leading magazines over a two-year period. More than 300 articles of this type were listed in the "Reader's Guide to Periodical Literature." Only about a dozen articles, Mr. Cunningham found, were critical even in part. That's less than 5 per cent.

What, then, has built up the myth of our profession's "bad press"? We suspect that it's a natural human sensitivity to criticism of any sort or amount.

We in medicine tend to magnify the critical articles out of proportion—as witness the statement of our Phoenix friend. People outside the profession take a much less alarmist view.

In fact, Mr. Cunningham concludes: "The public is impressed by critical articles about doctors and hospitals only to the extent that such articles confirm actual experience."

That means we needn't worry too

EDITORIALS

much about criticism of our profession in print. There's relatively little of it; and we have only ourselves to blame for the part that hurts.

Electronic Records

At the National Business Show, we spied a record card that jumps when you call it. You can file up to 5,000 of these cards any old way. When you want to summon one from the file, you simply push a key and the right card pops up. The secret? A coded metal strip at the bottom of the card, plus electronic controls.

We hurried back to the office and told our elderly secretary. "How much?" she sniffed suspiciously. About \$1,800 installed, we said.

"What if the thing breaks down?" she asked next. "Ever pawed through 5,000 cards filed any old way?"

We'd like to hear from some pioneer user of these modern marvels. But we're afraid we won't be it.

Practice Sales

The sale of a medical practice used to be part of the British tradition. Whenever an established physician was ready to retire, he could always count on plenty of prospective buyers. As a result, the price he got often ran as high as two years' gross.

Few British practices are sold any more. Under socialized medicine, the doctor has been deprived of his former right to set a price on "goodwill." But, meanwhile, in the

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Erythrosulfa

in refractory or
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ERYTHROMYCIN

the antibiotic of choice
against resistant
Gram-positive cocci . . .

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to cover Gram-negative bacteria
and to potentiate
the erythromycin . . .

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Erythromycin	100 mg.
Sulfadiazine	0.083 Gm.
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Sulfamethazine	0.083 Gm.

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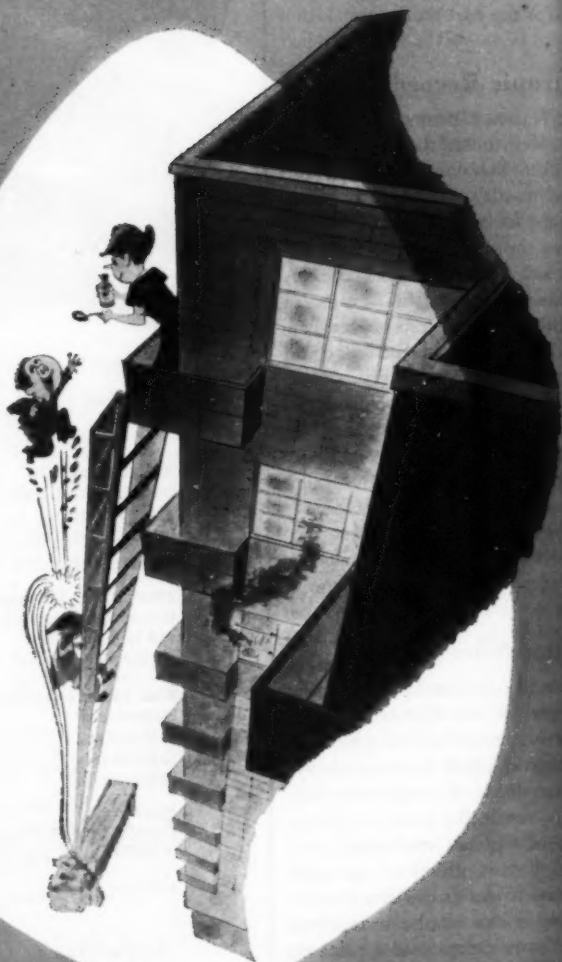
Protection-coated tablets
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(HOMOGENIZED MIXTURE OF VITAMINS A, D, B₁, B₂, B₆, B₁₂, C AND NICOTINAMIDE, ABBOTT)

the nutritional formula for growing children

A full day's serving of eight important vitamins (including 3 mcg. of body-building B₁₂) in each spoonful.

Delicious lemon-candy flavor and aroma. No pre-mixing, no droppers, no refrigeration. Mixes easily in milk, cereals or juices. Now with B₆ added. In

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*Each delicious 5-cc. teaspoonful
of Vi-Daylin contains:*

Vitamin A	3000 U.S.P. units
Vitamin D	800 U.S.P. units
Thiamine Hydrochloride	1.5 mg.
Riboflavin	1.2 mg.
Pyridoxine Hydrochloride	0.5 mg.
Ascorbic Acid	40 mg.
Vitamin B ₁₂	3 mcg.
Nicotinamide	10 mg.

PEDIATRICS

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

BULLETIN

Detection of Mediastinal and Cardiac Enlargement By X-RAY IN INFANTS

MANY CASES of unnecessary worry and concern result from faulty techniques in the X-Ray of chests of infants. The infant breathes rapidly, cannot hold his breath, and is often so uncooperative that it is not surprising that an X-Ray technician might fail to obtain a good film at full inspiration. The shape of the mediastinal mass and the heart in a film taken on expiration may be greatly distorted, particularly if there is even a little rotation.



● This affords an opportunity for the physician's self-education; to study a pair of films of a few healthy infants, one on full inspiration and one on expiration. The expiratory film may make the heart appear startlingly big and the mediastinum wide. To the unsophisticated, an inspiratory film following an expiratory film may give a completely satisfying picture of the effects of X-Ray therapy on the infant thymus.

● With the above in mind, the physician can beware of diagnosing a large heart or a mediastinal tumor in an infant—or a big thymus, if he is still interested in this ancient worry—on the basis of an X-Ray, unless skillfully taken and critically studied.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and appear monthly in Medical Economics.

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'Paveril Phosphate'

(Dioxyline Phosphate, Lilly)

relaxes vasospasm
increases exercise tolerance
lessens the frequency of pain

SUPPLIED AS:

1 1/2-grain and 3-grain tablets

AVERAGE DOSE:

1 1/2 to 6 grains three or four times a day, before meals and at bedtime



ELI LILLY AND COMPANY, INDIANAPOLIS 6, INDIANA, U.S.A.

EDITORIALS

United States, practice sales have increased. At least, that's what available evidence suggests; and it raises the question, "Why?"

For one thing, older physicians are realizing that they can recover their investment only by disposing of their practices *before* death or retirement. For another thing, younger physicians are realizing that the purchase of a practice can put them years ahead financially. In other words, the sale of a practice can be a good deal for both seller and buyer.

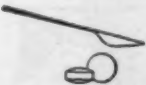
By former British standards, today's sales prices are bargains. One-half of annual gross is about as high as they run. You'll find more details elsewhere in this issue. They

help explain why an erstwhile British institution is today becoming Americanized.

Atomic Alert

So significant are the potential uses of atomic energy in medicine and in our peaceful pursuits generally that it befits us to keep an eye peeled for new developments, wherever they may occur. We're not quite sure whether the latest of these will be of most interest to obstetricians or to urologists. Either way, the future of a concern now listed in the Manhattan telephone book seems fraught with opportunity. It's called the Atomic Undergarment Company.

—H. SHERIDAN BAKETEL, M.D.



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Pleasant-tasting antacid adsorbent for prompt, lasting relief of gastric hyperacidity or management of peptic ulcer . . . without constipating effects.

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"That's what I'd call a 'Polysal recovery'!"



Polysal[®], a *single* I.V. solution to build electrolyte balance, is recommended for electrolyte and fluid replacement in all medical, surgical and pediatric patients.

Cutter Laboratories, Berkeley, California

ON EVERY COUNT... *superior*

*superior
flavor*

Both Poly-Vi-Sol and Tri-Vi-Sol have an exceptionally pleasant "taste-tested" blend of flavors, carefully protected throughout manufacturing. Both infants and children really go for Poly-Vi-Sol and Tri-Vi-Sol. And because all vitamins are synthetic, there's never any unpleasant aftertaste.

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Mead's years of research in the vitamin field made possible the development of outstandingly stable vitamin solutions. Poly-Vi-Sol® and Tri-Vi-Sol® require no refrigeration and may safely be autoclaved with the formula. And there's no need for expiration dates on the labels.



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Both Poly-Vi-Sol and Tri-Vi-Sol are in ready-to-use form . . . no mixing is necessary. The solutions are light, clear and free-flowing. Sanitary, individually cellophane-wrapped calibrated droppers assure easy, accurate dosage. For infants, drop directly into the mouth. For children, give from a spoon.

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Six essential vitamins for drop dosage

Each 0.6 cc. supplies:

Vitamin A.....	5000 units
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Ascorbic acid.....	50 mg.
Thiamine.....	1 mg.
Riboflavin.....	0.8 mg.
Niacinamide.....	6 mg.



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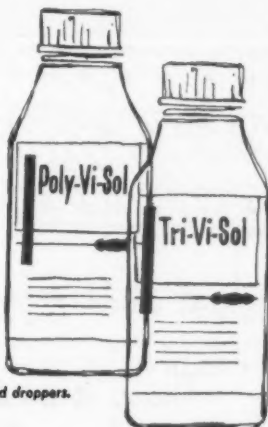
Vitamins A, D and C for drop dosage

Each 0.6 cc. supplies:

Vitamin A.....	5000 units
Vitamin D.....	1000 units
Ascorbic acid.....	50 mg.

*superior
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With all vitamins in synthetic (crystalline) form, and in a completely hypoallergenic solution, Poly-Vi-Sol and Tri-Vi-Sol are well tolerated even by allergic patients.

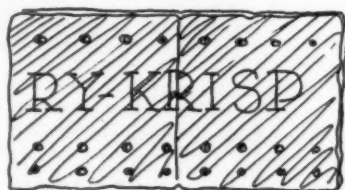
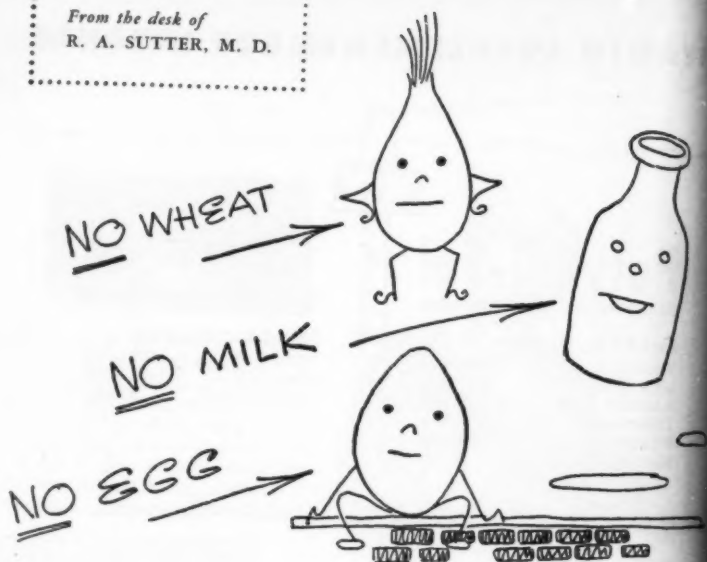


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THE bread in
Allergy diets!

Just whole-grain rye, salt & water

There is only
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not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes ... Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours ... Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

Prompt and prolonged relief with Tedral can be initiated any time, day or night, whenever needed, without fear of incapacitating side effects.

Tedral provides:

theophylline	2 gr.
ephedrine	$\frac{3}{8}$ gr.
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in boxes of 24, 120 and 1000 tablets

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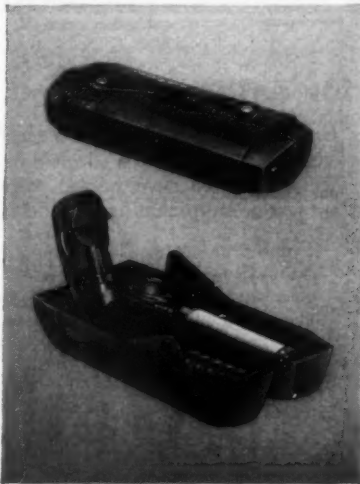
WELCH ALLYN

BETTER CASES for your instruments



Then Welch Allyn introduced this No. 21 Deluxe Case. It was the first sanitary case; it can be washed inside and out with soap and water or sterilized by wiping with alcohol. This feature, plus its modern appearance, compactness and extreme durability, have made the No. 21 Deluxe Case highly popular. It has been widely imitated.

Until four years ago, all diagnostic instrument cases were of this type: wood boxes, leather or leatherette covered, with plush lining. They were unsanitary and not very durable.



Now Welch Allyn again leads the way with the new No. 23 polyethylene one-piece molded case with patented self-hinge. It offers many of the advantages of the No. 21 Deluxe Case at a lower price, making it particularly suited for students and interns. It can be washed or sterilized with standard germicides, is extremely compact and practically indestructible. It holds Welch Allyn operating or diagnostic otoscope head attached to battery handle ready for use, any Welch Allyn ophthalmoscope head, spare bulbs and five otoscope specula. Available separately for use with existing Welch Allyn sets with medium battery handles or as part of complete sets. Your surgical supply dealer has the Welch Allyn No. 23 Case now.

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for inflammation,
neomycin
for infection:

1. **Neo-Cortef**

ointment (topical)

Each gram contains:

Hydrocortisone acetate 5 mg.
(0.5%) or 10 mg. (1%) or 25 mg. (2.5%)
Neomycin sulfate 5 mg.**
Methylparaben 0.2 mg.
Butyl-p-hydroxybenzoate . . . 1.8 mg.

Supplied:

5 Gm. and 20 Gm. tubes in plastic cases.

2. **Neo-Cortef**

ophthalmic ointment

Each gram contains:

Hydrocortisone acetate 15 mg. (1.5%)
Neomycin sulfate 5 mg.**

Supplied: 1 drachm applicator tubes

3. **Neo-Cortef**

drops (eye and ear)

Each cc. contains:

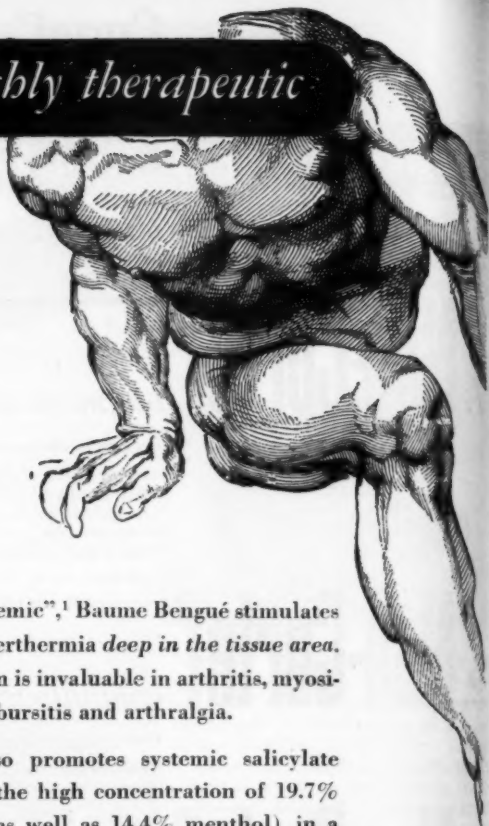
Hydrocortisone acetate 15 mg. (1.5%)
Neomycin sulfate 5 mg.**

Supplied: 5 cc. dropper bottles

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**EQUIVALENT TO 3.6 MG. NEOMYCIN BASE

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

thoroughly therapeutic



As a true "hyperkinemic",¹ Baume Bengué stimulates hyperemia and hyperthermia *deep in the tissue area*. This thorough action is invaluable in arthritis, myositis, muscle sprains, bursitis and arthralgia.

Baume Bengué also promotes systemic salicylate action. It provides the high concentration of 19.7% methyl salicylate (as well as 14.4% menthol) in a specially prepared lanolin base to foster percutaneous absorption.

I. Lange, K., and Weiner, D.: J.
Invest. Dermat. 12:263 (May) 1949.

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ANALGÉSIQUE

Available in both **regular** and **mild** strengths.

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Thoroughbreds are born, not made —



FROM THE ENGRAVING "HIS BROTHERHOOD" BY J. MARRIS. LONDON, PUBLISHED 1863 BY BAILY BROTHERS.

POLYOVOLINE is the ONLY tetracycline produced directly by fermentation from a new species of *Streptomyces* isolated by Bristol Laboratories . . . rather than by the chemical modification of older antibiotics.

**The most modern
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**POLYCYCLINE
CAPSULES**

(TETRACYCLINE *base*)



- 100 mg., bottles of 25 and 100.
- 250 mg., bottles of 16 and 100.

POLYCYCLINE

TRADE MARK



— the only tetracycline produced directly by fermentation from a new species of *Streptomyces* isolated by Bristol Laboratories... rather than by the chemical modification of older broad-spectrum antibiotics.



effective in broad range
against gram-positive and gram-negative organisms.



less toxic
(lower incidence of side reactions) than older broad-spectrum antibiotics.



more soluble
than chlorotetracycline (quicker absorption, wider diffusion).



more stable in solution
than chlorotetracycline or oxytetracycline (higher, more sustained, blood levels).

— the **ONLY**
oral suspension
of tetracycline that is
ready-to-use.

Requires no re-constitution, no addition of diluent, **no refrigeration**—stable at room temperature for 18 months. Has appealing "crushed-fruit" flavor. Supplied in bottles of 30 cc., in concentration of 250 mg. per 5 cc.



POLYCYCLINE SUSPENSION '250'

(TETRACYCLINE *base*)

Dosage: average adult,
1 gram daily, divided doses;
children in proportion
to body weight.



When you think of Tetracycline, think of **POLYCYCLINE**



How to Sell a Practice (or buy one)

Every year, several thousand doctors decide to relocate or retire. Their practices are usually worth more than the value of the tangible assets. But how do you price intangibles? How do you find a buyer? How do you arrange the transfer? Here's the full story of a typical practice sale

By J. P. Revenaugh

● For some years now, doctors wanting to sell their practices have outnumbered doctors wanting to buy them. This means that only the most transferable practices can be sold—and seldom for fancy prices.

What is a transferable practice? As a rule, it's an *active* one, with good current income; it's a *general* one, or at least not largely dependent on referrals; it's *well equipped*, with complete patient records; and it's *well located*, in an area where there isn't excessive competition. [MORE→]

THE AUTHOR is a medical management consultant. The firm in which he is senior partner, Professional Business Management of Chicago, has handled more than a hundred practice sales since World War II.

HOW TO SELL A PRACTICE

Such practices, in my experience, have sold for as much as \$65,000. But the average is probably below \$10,000. Note, for example, the prices of six consecutive practice sales in Illinois and environs:

¶ A general physician outside Chicago decided to retire, after thirty years in the same suburb. A younger man from the city bought his practice for \$9,000.

¶ After five years in a rural town, a young G.P. decided to take prolonged specialty training. He sold out his interests for \$5,500.

¶ A Chicago pediatrician was forced to move west because of his wife's health. His well-established practice went for \$7,000.

¶ Another metropolitan M.D.—an internist—found he was in the wrong neighborhood. Most of his patients were of a different national background from his. A colleague in the area seemed to suit the location better; he bought the practice for \$1,500 and combined it with his own.

¶ A 62-year-old physician in a small industrial city was offered a job with a research foundation. He took it, after selling out for \$8,500.

¶ A country doctor lived between two booming towns and maintained practices in each of them. When the load became too great, he sold one practice. The price included a custom-built medical office: \$25,000 complete.

What really constitutes a medical practice? In other words, what is it that the doctor sells?

There are, to begin with, the tangible assets: equipment, records, supplies, etc. There are less tangible things like the location and the lease. Least tangible of all are the patients' loyalties—their past loyalty to the seller, their prospective loyalty to the buyer. And therein lies the secret of successful practice sales:

Loyalty to the old doctor can be transferred to the new. Why? Because most people are creatures of habit. They will call the same telephone number; they will visit the same medical office; they will follow their medical records. They will do all these things if you encourage them.

Don't Make It Difficult

Conversely, if you discourage them, no practice sale can succeed. I remember the case of a young doctor in Indiana who bought a retiring physician's practice. The old man had been grossing \$2,000 a month; the young man couldn't seem to do better than \$250. A few months after the sale, he called on my firm for help.

What was wrong? The retiring M.D. had thoughtlessly given up his telephone number, let his secretary go, and taken the records away with him. Patients hadn't even been notified that a new doctor was available. It was too late to repair all the damage, but we did recover the records and get out an announcement. The very next month, the young doctor grossed \$1,500.

This case suggests another key point about practice sales: Such a sale has to be a good deal for the buyer as well as the seller. If it isn't, the buyer may have to default—and the seller may not be paid.

Increasing numbers of doctors recognize this. They are pricing their practices realistically. They are working out transfer details so that their successors will have every possible advantage.

The Steps to Success

How do they go about this? What are the specific steps that lead to a successful practice sale?

Two years ago, a physician I'll call Lloyd Leathers got in touch with my firm. He had practiced for twenty-five years in a residential community not far from Chicago (let's call it Arcadia). Now, at 63, his health was none too good. He wanted to move west and retire.

"Can you help me sell my practice?" he asked.

As it happened, we could. And because his case answers the questions raised above, I'd like to tell you about his experience in some detail:

The First Test

The first thing we wanted to find out was whether his practice seemed salable. "I do general medicine and some surgery," he told us. "My gross income came to \$32,000 last year."

Further investigation showed that

his income had remained steady for several years; that the three other general men in his neighborhood were approaching retirement age too; that the office he leased was located in the best part of town; and that his records were kept meticulously by a girl who'd been with him six years.

It checked: an active, general practice, well located and well equipped.

"I think we may be able to find a buyer," I told him. "That is, if the price is right . . ."

What's a Fair Price?

"Well, that's something I wanted to discuss with you," said Dr. Leathers, slowly. "I've put twenty-five years of hard work into building this practice. It seems to me it should be worth quite a bit—maybe \$25,000 or so."

[MORE→



"But don't you think it's glandular?"

HOW TO SELL A PRACTICE

"Sounds steep," I told him. "Remember, the prospective buyers are mostly young men. They can go into practice for themselves with a far smaller investment. They can go into group or partnership practice with no cash investment at all. If you're going to interest them in buying *your* practice, you've got to make it a really attractive bargain from their point of view."

"Well, then," Dr. Leathers said, "what do you suggest?"

"Let's start with your tangible assets. Do you have some sort of inventory?"

He did. After checking costs and depreciation, we estimated that the contents of his office (including leasehold improvements) were currently worth about \$5,000.

Minimum Demands

"We can get an appraisal later," I told him. "But let's figure that as the *minimum* you should take for your practice."

"I should hope so!" said the doctor, with some feeling. "Do you mean to say that practices sometimes sell for nothing more than the value of the physical assets?"

"Yes, sometimes. I recall one case where a young doctor paid just \$500 for records; the seller was moving to another state and taking his equipment with him. Yet, largely on the basis of those records, the buyer grossed \$25,000 in his first full year. Which proves there's more to a practice than the tangibles."

"Thank goodness for that," said Dr. Leathers. "I was afraid you were going to tell me that intangibles don't count. Now, how do you measure them? What's the best yardstick?"

The Income Yardstick

"Well, gross income gives some indication at least of the following a doctor has built up. Just how much of this following the new doctor can acquire depends on a lot of other things. But under favorable conditions, the buyer should be able to match your volume."

"He should also be able to match your net—and from the buyer's viewpoint, that's generally the more significant figure. All things considered, your net income is probably the fairest yardstick to use."

The doctor thought a moment. Then he said: "As I told you, my gross is \$32,000. After paying all my professional expenses, I'm left with net earnings of approximately \$20,000 before taxes. Would half that be too much to ask as compensation for the following I've built up over the years?"

Asking Price

"Let's say it's about the most you could ask for that sort of thing. Actually, in today's market, you might have to come down as low as one-quarter of your net—plus, of course, the appraised value of your physical assets. There's no formula that fits every case. But a good many

practices sell for the value of their physical assets plus one-quarter to one-half of annual net."

Dr. Leathers doodled on a scratch pad. "Then you're suggesting," he said, "that I may have to sell my practice for the value of my assets (\$5,000) plus as little as one-quarter, maybe, of my annual net (\$5,000), making a total of \$10,000 or so. That's a far cry from the price I had in mind."

"Yes. And don't forget," I told him, "that we're also a far cry from finding a doctor who wants to pay even the lower price."

Search for a Buyer

Over the next few weeks, we set about finding a purchaser. Dr. Leathers was instructed not to tell his patients about his decision (a practice can disintegrate fast if word gets around that the doctor is leaving). But he did tell other doctors about it—anonymously—through the classified columns of the state medical journal, a Chicago newspaper, and the Journal A.M.A.

Here is the advertisement we helped him devise:

ILLINOIS—GENERAL PRACTICE established 25 years; thriving residential area, excellent hospital facilities within 10 miles; well-equipped office with complete files; reasonable rent; desirable location on main street; gross income over \$30,000 each of last 5 years; terms arranged; moving out of state. Box 777.

Note that the ad mentioned all possible strong points and did not mention price. The idea was to produce as many contacts as possible with doctors who might be prospects. In all, the ad brought seven responses in a month—not bad for a competitive market. And one of the doctors seemed particularly interested; equally important, he seemed the right type.

The Leading Prospect

He was 35, this man. He'd been practicing as a salaried assistant in Chicago, and now he wanted to move out. His training was good and so were his references. Accordingly, Bill Covington (as I'll call him) was invited to bring his wife and spend the week-end at the Leathers' home.

The Covingtons liked the looks of the town—and of Dr. Leathers' setup. During the next month, the young doctor considered several other possibilities. Then, one morning, he strode into my office and announced:

"I'm ready to buy. But I warn you, I don't have much ready cash. What would you think of my paying Leathers a percentage of future income, instead of a flat sales price?"

About Percentage Deals

"Well, a fixed sales price is apt to be preferable," I replied. "After all, the practice has an ascertainable value as of this moment. If you get *more* than that value out of it, that's your doing; you shouldn't have to

HOW TO SELL A PRACTICE

pay extra for it, as you would through a percentage agreement. It would be unfair to you.

"And it would be unfair to Dr. Leathers if the opposite happened: if you made less out of the practice than you should, and therefore paid him less because of the percentage agreement.

"Of course, if we can agree on a fair sales price, you can pay it off in installments—there's no trouble about that. We think 25 per cent down and the balance within two or three years is a good way to clean it up."

There followed another week-end consultation between the two doctors. They had the contents of the office appraised; they talked with the secretary; they went over the record files. And finally they came together on the price: \$12,000, payable \$3,000 in immediate cash and \$300 a month later on (beginning three months after the transfer).

Down to Details

Now came the turnover planning. At a conference in my office, the two doctors went over the little details that, if not attended to in advance, can wreck a practice sale. Here's a brief summary of the points we covered:

RECORDS. "Am I violating any confidences if I turn over my patients' records as part of the sale?" Lloyd Leathers wanted to know. He was assured that the transfer of records was no different from their joint

inspection by any two doctors interested in a case: Both men were legally bound to respect the patients' confidences. Furthermore, he was told, if records aren't included, a practice generally isn't worth buying.

SECRETARY. The girl who kept the records would obviously be worth a lot to Dr. Covington. But she was reportedly uncertain about whether she wanted to continue. We recommended that she be offered a substantial raise to ensure her presence for at least six months. (A good secretary *can* be worth more than goodwill.)

LEASE. The sale was dependent on the transfer of Dr. Leathers' lease, which had two years to run at \$150 a month. The landlord had no objection, Dr. Leathers reported; so we anticipated no trouble in having the lease assigned to Bill Covington.

TELEPHONE. "My office phone number is easy to remember—3123," said Dr. Leathers. Even if it hadn't been, we would have recommended that the same number be transferred to Dr. Covington (it's part of the patients' habit pattern). Dr. Leathers was asked to get the telephone company's approval.

INTRODUCTIONS. Could Dr. Leathers stay in Arcadia a few weeks after Dr. Covington took over? It would smooth relations with the professional community—the physicians, the pharmacists, the hospital people. "I'll be glad to do the honors," Dr. Leathers agreed.

ACCOUNTS RECEIVABLE. These generally remain the property of the seller—but the buyer should collect them. "If Dr. Covington sends out bills in Dr. Leathers' name," I commented, "it helps to establish contact between old patients and the new doctor." Our recommendations: that accounts receivable be listed in duplicate at the time of sale; that they be collected through the office as usual; that proceeds be turned over to Dr. Leathers monthly.

RESTRICTIVE CLAUSE. "I know you plan to head west," I said to Dr. Leathers. "But suppose you don't like retirement; suppose you decide to resume practice. Dr. Covington ought to have some assurance that you won't directly compete with him." After asking whether the courts uphold such restrictions (they do), the doctors agreed on a clause that would restrain Dr. Leathers from practicing in his home town during the next three years. [MORE→



"Not those. My husband hasn't read them yet."

HOW TO SELL A PRACTICE

ANNOUNCEMENTS. People can be told about the transfer by formal notice or informal letter. Dr. Leathers felt strongly that an informal note would be most appropriate in his case. So the following letter was prepared for eventual mailing to all patients of record, over Dr. Leathers' signature:

"On the occasion of my retirement from active practice, I am pleased to announce that Dr. William P. Covington will take over my office. I have turned over to Dr. Covington all my case histories and records of treatment. In my opinion, he is well qualified to give you the same kind of care I have always tried to give you . . ."

How It Worked Out

Before that letter was mailed, the doctors went through a lot more detail work. Toward the end, they called in their lawyers. The result was the contract shown on the adjoining page—the legal instrument through which the practice was transferred on July 15, 1952.

Today, two years later, Dr. Leathers is enjoying life in Colorado. Although his health has improved, he has no desire to resume practice. Why should he? His finances are in good shape—thanks in part to the \$300 he has received every month from his successor in Illinois.

And what of Bill Covington? He's doing well too. He's grossing even more than Dr. Leathers did—the natural result of youthful energy ap-

plied to an old-established practice.

Two years ago, this young man was an \$8,000-a-year assistant in Chicago. By next year, when his Arcadia practice will be completely paid for, he should be grossing \$40,000 and netting \$24,000. Thus he will have succeeded in tripling his earnings by means of an investment of \$3,000 cash.

What Can Go Wrong

Hundreds of practices are sold throughout the United States each year, and most sales probably don't turn out this well. In many cases, the fault lies with the practice itself or the way it's turned over. But there are other common causes of failure. Note the following three:

1. *Wrong type of doctor.* A practice is built up over the years by the doctor's professional ability—and also by other things: his personality, his business methods, his activities in the community. If the buyer doesn't measure up to the seller in the eyes of his patients, the latter may not stick with the new man long.

Patients notice things you might not think of. Just recently, for example, a long-established suburban practice was sold for \$6,500. On the face of it, the practice was an excellent buy. But the buyer didn't prosper as expected.

Why not? Apparently because he was a married man, and the seller had been a handsome bachelor. Middle-aged spinsters comprised a good part of the patient list. Many

Excerpts From a Practice-Sale Contract

THIS AGREEMENT made this 15th day of June, 1952, by and between: Dr. LLOYD LEATHERS, hereinafter called the seller, and Dr. WILLIAM P. COVINGTON, hereinafter called the buyer.

WHEREAS the seller desires to sell his medical practice and business now being conducted in the offices at 99 Main Street, Arcadia, Ill., and the buyer desires to purchase said business;

NOW, THEREFORE, it is agreed by and between the parties hereto, for and in consideration of the mutual promises and agreements hereinafter listed, that the seller will convey his entire medical practice at such location, together with all furniture, fixtures, equipment, materials, supplies, patients' records, and other items listed in Schedule A, subject to the following terms and conditions:

1. The entire purchase price is agreed to be the sum of \$12,000, payable \$3,000 upon the signing of this agreement and the balance in monthly installments of \$300, beginning three months after delivery of the premises and business to the buyer on July 15, 1952 . . .

2. The consummation of the sale is agreed to be contingent upon the buyer obtaining a lease in his own name for a period of at least two years at a rental of \$150 per month.

3. The seller agrees that letters of announcement will be prepared and mailed to the patients of record, and the seller will furnish the stationery for this purpose. The buyer, however, will assume the cost of postage . . .

4. The seller agrees to permit the buyer to list his name in the telephone directory under the number ARcadia 3123 . . .

5. The buyer agrees to cause the mailing of statements at the end of each month on the accounts receivable owned by the seller. The buyer further agrees to deposit payments on such accounts to the seller's bank account, or follow whatever directions the seller issues . . .

6. The seller agrees that if he returns to the practice of medicine in the township of Arcadia, Ill., within a period of three years, he will pay to the buyer the sum of \$6,000 as liquidated damages . . .

IN WITNESS WHEREOF, the parties have hereunto signed their names and attached their seals.

Lloyd Leathers
William P. Covington

CAUTION: These excerpts are illustrative only and not for use without legal advice.

of them apparently decided to look elsewhere for their medical care.

2. *Wrong tax treatment.* Many sales have collapsed because the tax load turned out to be too heavy for the buyer. Take a case in point:

The senior physician in a two-man office was ready to sell out to the junior. They had a tremendous practice netting \$75,000 a year, of which the young man was getting one-third. He could foresee his own net income rising to at least \$60,000. So he tentatively agreed to pay the older man a whopping \$50,000 for "goodwill," spread out over five years.

Now, goodwill is never a problem to the seller, because he can treat the money he receives for it as a long-term capital gain. But it is a real problem to the buyer, because he can't deduct depreciation on goodwill (as on other capital investments) when making out his Federal income tax return. At the last moment, both doctors woke up to the tax implications:

The young doctor would have to pay about \$18,000 more in income taxes than he was already paying each year. That, plus his annual payments for goodwill, plus additional payments for the assets, would just about wipe out his income gain. In other words, he'd be no better off for five more years—and a lot more vulnerable.

At our suggestion, the deal was changed, and goodwill was taken out of it. Instead of making any pay-

ments labeled as goodwill, the junior agreed to share income with the senior for twenty-five months, at the rate of \$1,000 a month. This the young man could afford, because he wouldn't have to pay taxes on it. Nor would the income taxes be burdensome to the older man, since he'd then be in a lower bracket with extra exemptions (both he and his wife having reached 65).

The Widow's Mite

3. *Wrong timing of sale.* If, because of a doctor's advanced age or poor health, his practice has started to melt away, its actual value may be a lot less than its apparent value. And if the doctor has already died, it may be worth nothing at all beyond the value of the physical assets.

Doctors' widows often learn this lesson the hard way. One, for example, had been told while her husband was alive that his practice was worth \$40,000. Three weeks after he died, we estimated its value at \$9,000.

The widow held out for a higher price—and the value dropped some more. After another three weeks, she was lucky to sell it for \$5,000. Even at that greatly reduced price, the buyer got no bargain.

Selling *your* practice? Then don't wait too long. The only way you can get a respectable price—perhaps the only way you can get a buyer—is to make the necessary arrangements while it's active and flourishing. END

Things to Know About Investment Funds

Can you tell an open-end trust from a closed-end trust? Do you understand leverage and dollar cost averaging? Would you like to compare past performances of specific funds? A unique reference book gives most of the answers

By Mauri Edwards

● Wall Street in recent years has enjoyed an almost unprecedented boom. From 1949 through the end of last year (to use a convenient cut-off point), the Dow-Jones Industrial Average rose 74 per cent; and stock prices whooshed to a quarter-century peak.

Yet thousands of potential investors steered clear of this bull market. And many who did invest in common stocks had reason to regret it. Here's why:

1. In the midst of the big general advance, one stock in seven slumped.

2. One in four others either stood still or gained less than half as much as the over-all average.

The moral, according to most Wall Street brokers: This is indeed a good time to invest—if you invest wisely.

One of the safest places to put money is "in the modern investment company . . . known as the mutual fund,"* says Arthur Wiesenberger, senior [MORE TEXT ON 114]

*Most investors use the terms "investment company," "investment trust," and "mutual fund" interchangeably and somewhat loosely. In this article, the term "investment fund" is used to describe all types of investment companies.

TABLE 1
Twenty-Five Representative Open-End Investment Funds¹

	Year Begun	Assets (in Mil- lions)	Price Per Share	Loading Charge	Manage- ment Cost ²	Income Return	Aims	Change in Net Asset Value (1946-1953) ³
Affiliated Fund	1934	\$250	\$ 5.24	7.5 %	0.58%	4.2%	Long term capital growth from com- mon stocks	+ 3.6%
American Busi- ness Shares	1932	35	4.26	6.25	0.65	3.5	Income from diver- sified investments	- 1.9
Axe-Houghton Fund A	1934	32	10.09	7.5	0.95	3.2	Capital growth from stocks and bonds	+21.0
Boston Fund	1932	96	25.41	7.5	0.62	3.3	Income from con- servative stocks and bonds	+ 3.1
Broad Street Investing Cor- poration	1929	36	23.48	7.5	0.44	4.8	Income and capital growth from diver- sified investments	+ 13.5

Chemical Fund	1938	55	21.21	7.5	0.68	2.9	Income from single-industry shares	+ 29.6
Commonwealth Investment Company	1932	66	7.21	8.0	0.61	3.9	Income from stocks and bonds	+ 12.0
Delaware Fund	1937	15	17.10	8.5	0.98	4.0	Income, capital appreciation from common stocks	- 7.3
Diversified Investment Fund	1944	33	7.15	8.75	0.79	5.0	Income and capital preservation through stocks and bonds	+ 9.2
Dividend Shares	1932	120	2.02	8.67	0.74	4.0	Income from common stocks	+ 20.1
Eaton & Howard Balanced Fund	1932	102	33.33	6.0	0.59	3.7	Income from stocks and bonds	+ 53.5

¹All dollar amounts and percentages as of Dec. 31, 1953.
Dow-Jones percentage change was + 55.5%.

²Expressed as a percentage of assets. ³For purposes of comparison, the

TABLE I (Cont.)
Twenty-Five Representative Open-End Investment Funds¹

	Year Begun	Assets (in Mil- lions)	Price Per Share	Loading Charge	Manage- ment Cost ²	Income Return	Aims	Change in Net Asset Value (1946-1953) ³
Fidelity Fund	1930	\$ 92	\$18.63	7.5%	0.63%	4.8%	Income from stocks and bonds	+39.4%
Fundamental Investors	1933	156	20.84	8.75	0.63	4.4	Capital growth and income from com- mon stocks	+34.8
Gas Industries Fund	1949	22	20.67	7.5	0.76	2.9	Income from single- industry shares	+15.1 ⁴
Incorporated Investors	1925	131	11.19	7.5	0.54	3.7	Income from com- mon stocks	+31.6
The Investment Company of America	1933	26	6.28 ⁵	8.0	0.85	3.6	Appreciation from common stocks	+ 0.5
Investors Mutual	1940	512	15.26	7.5	0.56	4.1	Income from stocks and bonds	+ 10.9
Investors Stock	1945	58	17.95	7.5	0.58	4.0	Appreciation from	+30.6

Investors Stock Fund	1945	58	17.95	7.5	0.58	4.0	Appreciation from common stocks	+ 30.6
Knickerbocker Fund	1938	15	6.17	8.7	1.04	2.3	Appreciation from common stocks	+ 0.7
Manhattan Bond Fund	1937	25	8.44	8.75	0.77	4.3	Income from bonds	- 4.5
Massachusetts Investors Trust	1924	522	21.11	7.5	0.27	4.4	Income from equity-type Securities	+ 50.1
The George Putnam Fund of Boston	1937	67	19.47	7.5	0.64	3.9	Income from stocks and bonds	+ 15.2
Television-Electronics Fund	1948	29	7.40	8.25	0.79	3.8	Growth from single-industry shares	+ 41.4 ^a
United Income Fund	1940	72	13.11	8.0	0.75	4.9	Income from common stocks	+ 9.0
Wellington Fund	1928	280	21.78	8.0	0.50	3.7	Income from stocks and bonds	+ 9.3

^aAll dollar amounts and percentages as of Dec. 31, 1953. ^bExpressed as a percentage of assets. ^cFor purposes of comparison, the Dow-Jones percentage change was + 58.5%. ^dCovers the period 1949-1953. ^eCovers the period 1948-1953.

TABLE 2
Ten Representative Closed-End Investment Funds¹

	Year Begun	Assets (in Mil- lions)	Common Stock Asset Value	Price Per Share	Lever- age	Manage- ment Cost ²	Income Return	Aims	Increase in Common Stock Net Asset Value (1946-1953) ³
The Adams Express Company	1929	\$ 49	\$37.08	\$27%	None	0.56%	4.6%	Income from diver- sified common stocks	35.4%
American In- ternational Corporation	1915	21	23.39	17%	None	0.77	4.7	Income from diver- sified common stocks	24.2
Atlas Corpo- ration	1923	62	39.80	29%	None	1.83	4.4	Capital apprecia- tion from stocks	10.3
Consolidated Investment Trust	1933	31	30.73	29	None	0.20	4.7	Income from diver- sified common stocks	18.4
General American Investors Company	1929	47	22.52	20%	Low	0.66	3.2	Income from diver- sified common stocks	19.2

The Lehman	1929	143	34.38	33%	None	0.56	3.5	Growth from diver-	31.2
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Investors Company	1929	143	34.38	33%	None	0.56	3.5	Growth from diversified common stocks	31.2
The Lehman Corporation									
Newmont Mining Corporation	1921	141	53.24	40%	None	0.62	6.7	Investment in metals and oil	106.7
Tri-Continental Corporation	1929	176	28.20	15%	High	0.38	4.7	Appreciation from diversified stocks and bonds	139.8
U.S. & Foreign Securities Corporation	1924	91	77.07	48%	High	0.31	3.0	Income from diversified common stocks	115.0
U.S. & International Securities Corporation	1928	61	10.39	6%	High	0.51	3.5	Income from diversified common stocks	949.4

¹All dollar amounts and percentages as of Dec. 31, 1953.

²Expressed as a percentage of assets.

³For purposes of comparison, Dow-Jones percentage change was 58.5%.

INVESTMENT FUNDS

partner in the New York Stock Exchange firm that bears his name.

Mr. Wiesenberger, an ardent advocate of the funds, states his case in a 384-page, big-format volume entitled "Investment Companies."¹ Whether or not you want to buy the book (the latest edition costs \$20), you'll do well to consult it if you're seriously thinking of investing in the funds. It's a mine of dependable factual information about investment funds in general; it also gives a financial picture of most of the funds individually.

From the start, Wiesenberger's book eloquently pleads the case for the investment funds.² As an example, he cites this most recent period of boom, in which some stocks have floundered while others have soared. How have the funds been doing? Says Wiesenberger:

Almost all investment fund common stocks "advanced 50 per cent or more between their 1949 lows and the end of 1953 . . . The holder of investment company securities participated fully in the growing profits of American industry, because fund shares automatically provide a cross-section of the market."

Getting Diversified

During the same period, of course, the Dow-Jones average did

¹Published by Arthur Wiesenberger & Company, New York, 1954 (Fourteenth Annual Edition).

²For some arguments against this type of investing, see "Don't Go Overboard on Mutual Funds" (MEDICAL ECONOMICS, November, 1952).

even better than that. So—you may ask—why wouldn't *you* have got equivalent results by spreading your money over the entire Dow-Jones list? That way, you could also have avoided paying the heavy investment fund loading charges, couldn't you?

Wiesenberger's reply: "The cost of diversification may be prohibitive to the investor who tries to buy it directly." A year or so ago, for example, "to buy one share apiece of all the Dow-Jones [average] stocks would [have] cost \$2,383; and the combined expenses of purchase and sale would [have saddled] the small investor trying this expedient with a surcharge of 12.4 per cent"—as compared with the usual investment fund charge of 7 or 8 per cent.

A Convenient Package

In other words, buying the whole Dow-Jones list would be both a cumbersome and an expensive process. By contrast, the book explains, "investment company shares enable investors to buy . . . much wider and sounder diversification . . . in a convenient package with sums as small as \$50."

Wiesenberger also notes this significant advantage of the funds:

"Their operations are a matter of public record. They cannot bury their mistakes. No other form of investment management is under comparable compulsion to reveal errors as well as successes."

Not surprisingly, then, invest-

ment fund growth is considered by many brokers to be the market phenomenon of our time. In 1940, fewer than 1 million investors owned fund shares worth \$1 billion. Today, more than 2 million shareholders own fund shares worth \$5 billion. (In 1953 alone, gross fund sales were \$672 million.) By 1960, says the author, some 4 million Americans will probably own investment fund shares worth \$12 billion.

Started in Belgium

The wide popularity of investment funds has come about fairly recently. Not so the idea of "pooling individual resources to obtain the benefits of risk-cutting through diversification and central professional

management." This dates back, in fact, to the early nineteenth century.

In a brief historical section, "Investment Companies" says that the first known fund was begun by King William I of Belgium in 1822. The idea got to Scotland in the 1880s, and crossed the Atlantic about ten years later.

The first American company—Boston Personal Property Trust—was set up as more or less a family affair in 1893. It had a total capital of about \$100,000. And it still exists—with assets of nearly \$9 million and an unbroken record of dividend payments.

Today, it's just one of more than 200 active investment funds, all of them differing as to aims, methods,



"Marsha, how would you like to have free medical care for the rest of your life?"

INVESTMENT FUNDS

and degree of risk. "Thanks to this almost limitless diversity," says Wiesenberger, "the investor can find at least one investment company security to serve almost any purpose—subject always to the qualification that investment success can never be guaranteed."

It's in helping the investor make a choice that "Investment Companies" can be particularly helpful. For it analyzes the portfolio holdings, earnings, and performance of 173 different funds.

Open and Closed

Of these, 120 are the familiar open-end funds so popular in recent years, and fifty-three are closed-end funds. What's the difference between the two? The book puts it this way:

"The closed-end company . . . like ordinary companies . . . has a fixed capitalization. Its shares have been issued at some time in the past, and new shares are not continuously available directly from the company. [The issued] shares are usually traded on the New York and other national security exchanges.

"One buys these shares exactly as one buys any other . . . security. Consequently, the supply and demand for closed-end shares have an important effect on their prices. In this respect they differ fundamentally from open-end shares, which are priced on the basis of their asset values."

The open-end funds are usually

set up to offer new shares continuously. The offering price of a fund share is determined solely by the asset value of the issues that make up its portfolio. The supply of fund shares—and the demand for them—doesn't enter into the price at all.

As a result, these shares usually aren't traded on the stock exchanges. Instead, they are bought through authorized investment dealers. A few companies have their own direct sales representatives.

Such distinctions, while important to the broker, are largely academic to you and me. Probably more vital, from our point of view, is a knowledge of the management policies and characteristics of the individual investment funds.

What Are Your Aims?

The right fund for you to invest in is, obviously, the one whose aims approximate your own. Are you interested chiefly in *income*, for example? Or are you concerned mostly about the *safety* of your capital? Or is *appreciation* in rising markets what you're seeking mainly?

These are the three most common investment aims. And Wiesenberger points out that there are dozens of funds to suit each of them.

If it's income you're after, the detailed records in "Investment Companies" will show you which funds have paid a reasonably high, steady return over the years. If, on the other hand, you're focusing on the safety of your capital, you'll find a number

of balanced funds that gear their investments to the fluctuating value of the dollar.

Finally, if it's appreciation you want (and you needn't be a speculator to fit into this category), you may be especially interested in the so-called leverage shares. As the book makes clear, these tend to move faster than the market—"and naturally in both directions."

The Leverage Story

Just what is leverage? According to "Investment Companies," it's the speculative force that steps up the rate at which a fund's earnings zoom or dive. This force is measured by the prior claims of the company's preferred stocks, bonds, or bank debt. If a stock has no debt or securities senior to it, it's of the non-leverage type. If the senior claims are few, the stock is then a low-leverage issue. If there are numerous senior claims ahead of it, it's a high-leverage stock.

Suppose, for example, an investment fund has \$10 million in assets and has issued 1 million common shares. Suppose it owes \$2 million to banks; it has \$3 million in outstanding bonds; and it has issued \$4 million, at par value, of preferred stock.

That makes \$9 million tied up in senior claims. So only \$1 million is left for the common shares—or \$1 per share. Clearly, this is a high-leverage venture.

Along comes a bull market, and

the fund's assets double in value. But notice: Senior claims are still only \$9 million. So now there's \$11 million for the common stock—\$11 a share, or a rise of 1,000 per cent, stemming from a gain of just 100 per cent in the total value of securities held by the fund.

Sounds fine? Well, it is. But what if the market goes in reverse? Then the holders of common stock will lose their money equally fast. And if the fund's assets shrivel to less than \$9 million, they may be left holding the bag.

Up! Up! Up!

To see leverage in actual operation, take a look at two closed-end companies—American International and U.S. & Foreign Securities. Early in 1942, American International's senior claims amounted to 62 per cent of its assets, leaving 38 per cent for the common shares. That's a moderate leverage situation. U.S. & Foreign, on the other hand, had senior claims amounting to 94 per cent of its assets—high leverage, indeed.

That year, American International common hit a low of \$2¼ a share, while U.S. & Foreign dipped to \$2½. Then came four years of bull market. In 1946, the per-share asset value of American International common reached \$16¾—a gain of 495 per cent. Meanwhile, U.S. & Foreign common, with its much higher leverage, jumped 1,200 per cent—to \$32½. (In that period, incidentally,

INVESTMENT FUNDS

the Dow-Jones average climbed just 129 per cent.)

American International later retired its senior obligations and became a non-leverage fund. U.S. & Foreign also retired many of its senior claims and is now a moderate leverage fund. Both these funds have continued to climb in recent years—but not so spectacularly as in the early Forties.

Leverage isn't usually a factor in open-end funds; but there's still plenty of choice available to the investor who shops around for a fund of this type. He can buy shares in an all-bond fund, in a preferred stock fund, or in a specialized fund made up entirely of common stocks from a single industrial field.

The majority of fund investors,

however, buy shares in either diversified bond-stock funds or diversified common stock funds. These two categories spread-eagle the field.

When the investor has selected the fund that looks best to him, he can, of course, buy shares according to any plan he chooses. But for long-term investing, Wiesenberger strongly recommends a system of regular investments of equal size.

Dollar Averaging

Wall Street men speak of such systematic investing as "dollar cost averaging." Wiesenberger calls it "a means of turning to one's advantage the fact that stock prices do fluctuate and of capitalizing upon declines in stock prices when they occur." He gives the following example of how



© MEDICAL ECONOMICS

"What's good for appendicitis?"

dollar cost averaging works:

"Assume that a rapidly declining market develops at the start of an accumulation program and that an investor is able to make three successive purchases of the same stock at \$10, \$8, and \$5 a share. If he invests \$1,000 each time, he will obtain 100 shares with his first purchase, 125 shares with his second, and 200 with his third, a total of 425 shares. (For the sake of simplicity, all purchasing costs are ignored in this example.)

"The average of the three prices paid is \$7.67. Obviously, the investor is better off than he would have been if he had made his entire investment at the starting price of \$10. But he is also better off than he would have been if he had invested the \$3,000 in a lump sum at the average price of \$7.67. At that price, he would have obtained only 391 shares . . . instead of the 425 shares shown above."

Why is this so? Explains Wiesenberger: "The same number of dollars buy more shares when the price is low than they do when the price is high. The 200 shares bought at \$5 nearly equaled the total of shares bought at \$10 and \$8. This served to reduce sharply the average cost of all the shares purchased—to \$7.06 a share . . . \$0.61 below the average of the prices paid."

To be sure, this example is an extreme one. Few investment funds are likely to lose half their asset value; you, as an investor, obviously hope they won't decline at all. "But

as long as purchases are made at varying prices, and equal amounts of money are invested each time," says the author, "the average cost of shares acquired will always be lower than the average of the prices paid."

The Latest Wrinkle

To give more investors an opportunity to benefit from dollar cost averaging in buying investment funds, many of the funds now make available a variety of so-called accumulation plans. Some of them, writes Wiesenberger, "accept as little as \$10 monthly; some have higher minimums; some have no specific requirements at all. [So] even the smallest investor can begin a plan for systematic investment."

Apparently, the idea of dollar cost averaging is taking hold in the U.S. Three years ago, only twenty-eight investment funds offered accumulation plans. Now "Investment Companies" lists ninety-two.

That's not all. Where only about 50,000 persons were buying fund shares through such plans three years ago, "today, these invest-as-you-go plans have 200,000 investors who are investing . . . \$72 million a year. This represents about 10 per cent of 1953's gross mutual fund sales."

In view of all the evidence, then, is there any reason to be timid about buying stocks? Not, maintains Wiesenberger, so long as you "invest the modern way"—by putting your money regularly into the investment fund best tailored for you. **END**



He Made a Movie To Help His OB Patients

By Edwin N. Perrin

● "You'll never make any money. You waste too much time talking to your patients."

That's what Dr. Paul Seyler's secretary said to him a couple of years ago. She spoke half in jest; but the young Dayton, Ohio, obstetrician took her words to heart.

"The fact is," he now says, "I *was* talking too much. A lot of doctors—especially Ob./Gyn. men—make this mistake. They want to explain things to their patients (and quite properly so); yet every explanation burns up valuable time."



FILM STRIP shows obstetrician Paul Seyler examining Mrs. John Sperry, who "starred" in his educational movie for prospective mothers. On facing page, sound track is added to film by Dr. Seyler, assisted by his wife, Karla, and a neighbor, Mrs. M. H. Bolender (center).

So Paul Seyler decided to prove his aide's prophecy false. Result: He no longer spends hours discussing the facts of pregnancy with future mothers. Instead, he shows them a motion picture.

"It works wonders," he says. "They like being *shown* childbirth, instead of simply being told about it. And I'm delighted because I now have extra time for more important things than just talk."

The doctor himself directed, produced, and manufactured the film, which he screens twice a month in his office. But it wasn't his original intention to make the picture himself.

"First, I hit on my idea for a time-saver: a movie that could be shown to a dozen patients at a clip," he explains. "Then I looked around for one."

As he envisioned it, the film would portray the birth process from first-month check-up

HE MADE A MOVIE

to delivery-room episiotomy. And it would be more than just a time-saver: It would explain birth to the average patient rather more understandably than any book or lecture could.

He Gets Camera

But he searched through all the standard lists of educational films, without success. None of the available material seemed right for his purpose. He had about given up when his mother-in-law came to the rescue: She gave him an eight-millimeter movie camera as a Christmas present.

That was in December, 1953. Until then, it hadn't occurred to him to make a film of his own. But now that he had the camera—well, the idea seemed irresistible. He mapped out his plans and got to work.

Only a few months later, he completed "A Family Affair." On June 30, 1954, he put the finishing touches to the film. It was an hour long; it was in full color and sound. And it was ready to go.

A Movie Is Born

Dr. Seyler himself did virtually all the photography and writing for the picture. "He chose the musical background, too. His wife Karla (a former nurse, whom he'd met, appropriately, in the delivery room at Cincinnati General Hospital) acted as narrator. And the two of them, with the help of some technically minded friends, dubbed in the sound track.

Dr. Seyler figures that the finished job cost him between \$500 and \$700.

Naturally, not everything went smoothly with the production. The young physician made several false starts, for example, before he finally hit on a satisfactory continuity. In the beginning, for one thing, he used up footage on about fifty different patients. Then he got the idea that finally gave "A Family Affair" much of its warm appeal: He humanized and personalized his story by concentrating on the pregnancy of one woman only.

The "stars" of the show, whom the doctor hand-picked from among his patients, are a young couple in their twenties, John and Sally Sperry. Both are photogenic; and both were remarkably cooperative.

Stand-Ins for Sally

"We loved making the picture," Sally Sperry says today. "It was a lark. But it was more besides. It gave added meaning to my own pregnancy."

The Sperrys appear throughout the movie—except in the actual examination and delivery scenes. For these, which are notably graphic, the doctor used shots he had taken of various patients. All the "actresses," of course, remain unidentified.

"I didn't want to leave *anything* to the imagination," Dr. Seyler explains. And he hasn't. The color film shows X-ray pelvimetry, vaginal examination, and the full routine of

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delivery. There's even a shaving scene.

"A Family Affair" had its premiere at Dayton's Miami Valley Hospital (where much of it had been filmed) on July 1, 1954. Dr. Seyler ran the projector; and a first-night audience of about a hundred (physicians, hospital employees, guests, and everyone who had helped in the filming) sat out front.

Almost without exception, those who saw the movie then—like those who have seen it since—were enthusiastic. "The picture will help any new father and mother, and even many of the old ones," said a local pediatrician. "It's a superb professional job," commented another doctor.

One of Dr. Seyler's patients wrote him a glowing thank-you note. "Bless you for caring enough about us mothers to make such a movie," she said.

His Big Night

But no one was quite so delighted as the movie-maker himself. "This is my production and my night," he told a friend at the opening. "And I couldn't be more thrilled. I only wish I could show the picture to every parent in the country."

So far, that hasn't been possible. But Dr. Seyler *has* managed to get a gratifyingly wide circulation for "A Family Affair." He has held office showings twice a month for patients, as originally planned. In between, and at his own expense, he has

screened it for a variety of clubs and civic groups in and around Dayton. Audiences have numbered as high as 200.

His Future at Sea

As of now, though, the doctor's career as a movie-maker is temporarily in abeyance: He has been recalled to a fifteen-month tour of duty with the Navy. Even so, he insists, he'll find time for some preliminary work on his next film.

"It's going to deal with the problem of infertility—frankly and helpfully," he says.

After that, he wants to do a movie explaining sex to teen-agers.

"The Navy's a pretty good place for research," he adds, philosophically. "On that second subject, at least, it *ought* to be."

END



"You're the only reason I want to get well!"

Here Are the Practice Costs You Can Tax-Deduct

*You'll save money by using this checklist when
you fill out your 1954 Federal income tax return*

By John C. Post

● When you figure out how much to deduct for professional expenses on your 1954 Federal income tax return, you'll probably concentrate on the big items like car upkeep, depreciation, and rent. That's as it should be—provided you include all other deductibles, too.

The following list should serve as a convenient jog to your memory. It describes, in alphabetical order, the thirty-one major deductions for practice costs now allowed by the Internal Revenue Service.

ACCOUNTING: Amounts paid for bookkeeping, preparation of tax returns and estimates, and general auditing.

AUTOMOBILE: Full operating cost if automobile is used only for professional calls or if other use is inconsequential. No part of cost if use is solely for transportation between home and office. Proportionate cost if part of use is nonprofessional. When permitted as business deduction, auto upkeep includes chauffeur's salary and uniform; depreciation; repairs; tolls; towing; garage rent; gasoline; oil; insurance premiums (fire, theft, collision, liability, etc.); lubrication; license fees; loss or damage not covered by insurance; loss on actual sale of automo-

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bile, with depreciation considered; tires and tire repair; inspection fees; parking charges; and auto club dues.

BAD DEBTS: Arising from business loans or services performed, *but only if previously reported as income*. You must claim the deduction for the year in which the debt has become worthless.

CLUBS: Dues and expenses, if they're necessary for maintaining your business or professional contacts. These include payments to service clubs and chambers of commerce if such membership is intended to benefit you in a professional way. (Itemize amounts, name organizations, and be prepared to prove necessity.)

COLLECTIONS: Expenses incurred in collecting professional accounts—attorneys' fees are included.

CONTRIBUTIONS: Amounts, up to 30 per cent of adjusted gross income, given to recognized charitable organizations—provided that no more than 20 per cent of your income goes to charities *other than* churches, hospitals, or educational institutions. To be deductible, contributions need not be made in cash. If property or securities are given, deduct their market value.

CONVENTIONS: Cost of transportation to and from out-of-town meetings; cost of rooms, meals, tips, etc.

CREDIT BUREAU FEES

DEPRECIATION: On all your professional property, including automobile, instruments, books, equipment, furniture and fixtures, or any other asset having a useful life of more than one year.

ENTERTAINMENT: Meals, drinks, theatre tickets, admission to games, transportation, and similar costs *if* they are "ordinary" and "necessary" to your practice.

EQUIPMENT: Books, instruments, and equipment used in your professional work and having a useful life estimated at one year or less; also rental of equipment necessary to practice.

[MORE→

PRACTICE COSTS YOU CAN TAX-DEDUCT

GIFTS: If ordinary and necessary to your practice, and if benefit can be proved. (See ENTERTAINMENT.)

INSURANCE: Premiums on policies in connection with your profession, covering accident, burglary, public liability, fire, storm, theft, or malpractice; also indemnity bonds on office employees.

INTEREST: On practice-connected loans and mortgages. In installment contracts where the interest rate is not specifically stated, you may deduct 6 per cent of the average monthly balance during the taxable year (but not more than the carrying charge itself).

JOURNALS AND BOOKS: If estimated to have a useful life of one year or less. Most medical journals and books are in this category. Cost is one determinant. For example, a set of books costing \$100 probably would not be allowed as a current expense. But yearly depreciation on such books would be allowed.

LEGAL: Litigation expenses in connection with your practice.

LICENSES: Physician's annual license fee.

LOSSES: Losses not covered by insurance (or in excess of insurance collected) that result from property damage caused by fire or acts of nature; damages paid as a result of civil suits against you arising out of your profession; business bad debts; theft losses; damage to your auto.

MAINTENANCE: All maintenance expenses of a building used entirely as your office. Proportionate cost if

part is used for office, part for home. Maintenance includes such items as heat, light, water, repairs, painting, decorating; wages paid to janitors and elevator men; payroll taxes; and depreciation.

MEDICAL SOCIETY DUES

MOVING: Such expenses if in connection with a continuing practice.

POST-GRADUATE COURSES: The cost of such study if it's of direct help to you in your present practice. In other words, the course should merely enable you to do your current work more efficiently—not to shift, say, to a different specialty.

RENT: If paid for professional equipment or office quarters. If only part of your residence is used for business purposes, only a proportionate part of the rent is deductible.

REPAIRS: Repairs to your office, including cost of decorating, painting, patching, alteration (other than permanent improvement); putting property in safe and efficient operating condition; new surfacing; repairs to roofs; repairs necessitated by a casualty, such as explosion, fire, or hurricane (not including capital restoration). Also covered are repairs to medical and business equipment.

SALARIES: Paid to secretaries, assistants, substitutes, and other professional aides and consultants. Also the Social Security taxes (not employee's share) paid on such salaries. If an employee devotes only part of her services to your professional establishment, deduct a proportionate part of her salary. (Wages of domes-

tic servants ordinarily include value of food and lodging, light, and special privileges furnished them.)

SUPPLIES, MEDICAL: Dressings, vaccines, drugs, etc., consumed during the year. (See EQUIPMENT.)

SUPPLIES, OFFICE: If used in your practice, including bills, cards, and envelopes; labels, letterheads, and printed forms; ink; postage.

TAXES: If incurred in the production or collection of income. Under these conditions only, you may deduct taxes on admissions; bond transfer stamps; taxes on cable messages; customs and import duties; deed stamps; taxes on dues, on initiation fees, on property transportation, on radio messages, on safe deposit boxes; stock transfer stamps; taxes on telephone and telegraph messages, on local telephone service, on transportation of persons, on equipment services.

TELEPHONE AND TELEGRAPH: Such costs when incurred profes-

sionally (including a "fair" share of the expense of your home phone, if so used).

TRAVEL: Expenses of going to conventions affecting your practice, including baggage transfers, lodgings, meals, railroad fares, plane fares, boat fares, bus fares, telegrams, tips.

UNIFORMS: Purchase price and laundering costs, on the theory that the uniforms are required by custom or for reasons of cleanliness. Such uniforms must not be suitable for ordinary wear.

NOTE: *Don't forget that elsewhere on Form 1040 you can deduct a number of nonprofessional expenses as well. Among them are casualty losses; legal fees; maintenance of rented-out property; losses from asset sales; interest payments; and many state and local taxes (real estate, income, personal property, sales, cigarette, and—in some states—gas and liquor taxes).* **END**

Last Straw

● The doctor decided to tell the patient the truth. "I feel I must tell you," he said, "that you're a very sick man. I can't offer you much hope. Now, is there anyone you would like to see?"

The patient beckoned him close and whispered feebly, "Yes."

"Who?"

"Another doctor!"

—RUTH CAMP



MEDIC'S CREATOR, James Moser (above), works hard to see that his scripts have true medical flavor. At top left (facing page), he gets briefing on laboratory techniques from Dr. J. Philip Sampson, president of the Los Angeles County Medical Association. At top right, Moser and the show's producer, Frank La Tourette, discuss the case of a young traction patient with Dr. R. V. Gentry, head of the medical society's radio-TV committee.



'Medic' Does Job for M.D.s

Here's a behind-the-scenes look at the remarkable new television series that at last gives the public an authentic glimpse of doctors at work

By Wallace Crootman

● Television has found a brand-new doctor—one who is nothing like the white-frosted huckster that used to peddle cigarettes, cold cures, and laxatives. The new man is a grim-faced, raspy-voiced individual with the TV name of Konrad Styner; and he serves as host, narrator, and sometimes star player on N.B.C.'s dramatic series, "Medic."

In the past few months, Medic has established itself

Medic's serious tone is borne out by these scenes from initial episode . . .



Doctor tells husband wife has leukemia . . .



Child is delivered after mother has died...

as a top-ranking TV show. It has already cut into the popularity of the established "I Love Lucy" series, which runs at the same Monday night hour over C.B.S. The Dow Chemical Company, Medic's sponsor, says in its national advertising that it's "proud to present a program of such exceptional merit."

Organized medicine, too, is happy about the new program. The Los Angeles County Medical Association assists in the preparation of the show and has given it its official seal of approval. And George F. Lull, secretary and general manager of the A.M.A., says he looks forward to seeing Medic every



Pregnant wife learns she's going to die . . .



O.R. crew assembles for 3 A.M. emergency...



Anxious doctor listens to faint heartbeat . . .



Child saved, doctors relax with smoke . . .

week—and hopes that other doctors do, too.

Dr. J. Philip Sampson, the Los Angeles association's president, hails the series as "a new concept in television drama, which for the first time blends a dramatic presentation with a faithful reproduction of medical techniques."

Here, as never before, he adds, "television informs while it entertains."

It's clear, in fact, that just about everybody is taking this new program seriously. And since patients are starting to question their doctors about the techniques demonstrated on the show, it's high time

practicing physicians got a glimpse of Medic backstage.

Let's begin, then, with a look at James Moser. He's the man who dreamed up the idea of a really authentic series of medical dramas; and he's the man who now writes them.

Realism His Goal

Moser—a lean, serious-minded young man in his mid-thirties—labors mightily to achieve what the N. B. C. promotional department calls the show's "rusty-nail realism." If a story is to deal with deafness, for instance, he prepares for it by temporarily wearing a hearing aid; if he's planning a script on polio, he actually takes the trouble to crawl into an iron lung.

In particular, he tries to avoid the sweetness-and-light approach that falsifies so many popular presentations of medical themes. "If we're going to approach the world of medicine honestly, we have to show both life and death," he says. "They can't all be happy endings."

He showed his serious intentions, last September, in his very first production (scenes from which are reproduced in these pages). The story dealt with a pregnant woman who had acute leukemia, and with Dr. Konrad Styner's fight to save the child. The doctor won the fight—but only after the mother had died.

As his Christmas-week offering this month, Moser has written another unusually naturalistic play: an

account of the tragic aftermath of a too-merry pre-Christmas office party. At the season when even hard-bitten TV detectives generally take time out for tree-decorating, Medic's Konrad Styner will introduce "the case in point: Frances Monahan." Her story, he'll explain, "concerns a threat to human life about which the doctor can do little [except by giving] his best to correct the damage inflicted . . ."

Styner plays no direct role in the drama that follows. The main characters are a neurosurgical resident (Max Konrad) and an interne (George Rosenthal). Early in the episode, which takes place on Christmas Eve, the two doctors and a nurse (Julie McCabe) hear an ambulance siren growling outside their post in the hospital's neurosurgery admitting room. Their reactions set the tone for the grim business to come:

ROSIE: Wheels . . . [starting to rise]. Here we go. [He goes to the water cooler for a drink.]

KONRAD [glancing at wall clock]: Never fails . . . Right on schedule.

MCCABE [crossing over into the treatment room]: Just about. Little early, if anything.

Konrad and Rosie move to the window in the treatment room and look down at a driveway. The camera picks up what they see: a stretcher case being removed from the ambulance.

KONRAD [grunts]: What d'ya know . . . brand-new ambulance.

ROSIE: How'd they ever guess?
... Just what I wanted for Christmas.

From this point on, the two men struggle successfully to save the life of Frances Monahan, a young woman who has been badly hurt in an auto accident. At first they pay little attention to George Otis, the belligerently drunk—and unhurt—driver of the wrecked car in which she was a passenger. Otis wants to go home; he's told several times that "nobody's keeping you here." Finally, though, Konrad's pent-up emotions spill over:

KONRAD: I have a suggestion for you, Mr. Otis . . . I suggest you wait a little longer. Wait until the girl's mother gets here. You can listen while I explain the condition her daughter's in. Or maybe you'd like to do the explaining yourself.

OTIS: That's your job, not mine.

It's Konrad's Job

KONRAD [nodding]: That's right, it's *my* job . . . You might learn something from it . . . You can hear the kind of questions they ask . . . You can see the heartbreak and misery in their faces when we give 'em the answers. Believe me, it'd be a lot easier to lie . . . And it won't be any easier with the girl, when the shock clears up . . . She's gonna ask questions . . . I'd like to have you there, Mr. Otis . . . I'd like very much to have you there . . . Because you know what her first question's gonna be? You know what she's gonna

ask? [Brief pause.] She's gonna ask, "Why is it dark?"

OTIS [reacting; puzzled]: What d'ya mean? You said she'd be all right . . .

KONRAD: I said she's out of the critical stage . . . There's not much doubt she'll recover.

OTIS: Then what're you getting at? Why would she ask if it's dark?

KONRAD: Because it is dark, Mr. Otis. She's blind . . . Both eyes . . . completely macerated. She's blind for the rest of her life . . . What about it, Mr. Otis? Would you like to wait around?

M.D.s at Their Best

Despite the grimness of scenes like these, most doctors who have worked with Medic expect the show to do medicine a lot of good.

For one thing, all Moser's stories aren't tragic. For another, when they are, it's always made very clear that the tragedy would have been worse but for the intervention of devoted physicians.

As Jerry L. Pettis, executive assistant to the president and public relations director of the Los Angeles County Medical Association, puts it:

"This show gives the profession a chance it's never had before to propagandize medicine's good side. And the really good part is that the job is being done unobtrusively, in the natural course of the dramatic sequences."

In the cold black-and-white of a brochure, says Pettis, it's hard to get

MEDIC DOES JOB FOR M.D.'s

across the fact that doctors' fees are small enough reward for the job they do. "It's far easier, in a show like *Medic*," he says, "to have a scene showing a woman up against it financially. She's seriously ill—and worried about money. So she tremulously asks, 'How much do I owe you, Doctor?' When he answers—with all the sympathetic understanding in the world—'Don't worry about it now; let's just get you well first,' it's worth more than 10,000 words in convincing the public of the profession's altruism."

You don't have to be intimately connected with *Medic* to recognize the unobtrusiveness of the sort of

message Pettis mentions. Independently, an East Coast medical man who'd just seen the first show remarked to the writer of this article that he'd found the pro-M.D. message "far more subtle than anything organized medicine usually goes in for: The show depicted a doctor willingly getting up in the middle of the night; it showed a whole O.R. crew sweating at 3 A.M.; it set the stage so that there wasn't a doubt that the baby would have died but for the doctor's stubborn refusal to give up."

Understandably, *Medic* concentrates on the clinical—not the economic—side of its patients' problems.



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"Tan I have a waise?"

Doctors' fees are mentioned incidentally, if at all. But patients of modest means invariably find that skilled personnel and modern facilities are readily available.

In one episode, for instance, a pretty 19-year-old girl is stricken with a heart attack as she climbs up the stairs to meet her sweetheart. Though she obviously has little money, she's restored to health through the services of a distinguished cardiologist, who not only clears away the scar tissue blocking her mitral valve but gets her heart going again when it stops during the operation.

Medic will continue to stress the ways in which doctors serve the public. The Los Angeles County Medical Association insists that, as long as it endorses the series, the profession will be shown in the best possible light.

How It's Checked

Under their agreement with Medic's producers, the Los Angeles doctors study each episode from the time the rough idea is conceived until the final film version has been put together.

Step one in the authenticating process is a weekly meeting between Jim Moser and the medical society's TV committee. At these meetings, Moser presents his ideas for future dramas. The doctors have the power to accept or reject any of his suggested themes.

So far, they've been pretty broad-

minded about the subject matter. (The leukemia episode is just one example of their willingness to handle delicate themes.) But they have vetoed a few ideas—notably the following:

Not Everything Goes

¶The story of a homosexual and his frantic search for help. ("Too sensational," the committee decided. But it agreed to reconsider the theme after the show has become more firmly established.)

¶The story of a "bad doctor" who is brought to justice by the grievance committee of his local medical society. ("Not in line with our policy of showing the profession in a good light," ruled the committee.)

¶The story of a student's struggle to get through medical school and set himself up in a community. (The committee's comment: "The idea doesn't seem to fit the show's format.")

Copy Conference

Once it has approved a subject, the committee chooses a Los Angeles physician who's an expert in the field, and sets up a meeting between this specialist and Moser. After absorbing some of the specialist's views, the author turns out a rough script.

Copies of his first draft go to each member of the doctors' TV committee, as well as to the specialist. A week or so later, the medical men and the writer get together for a

rough-copy conference; and the script is gone over line by line, with committee members making copious comments. Moser then incorporates all necessary changes in his final version.

And quite a few changes are usually called for. On one occasion, the committee was shown a script in which the older member of a surgical team decided, over his younger colleague's violent opposition, not to operate on a child with a critical head injury. (In Moser's original version, the patient later died, just as the younger man had predicted.)

After one look at this scene, the physicians got out their blue pencils. "We will *never* show two doctors disagreeing on the management of a case," they said.

'I Couldn't Do It'

Another time, Moser depicted a doctor as doing a remarkable bit of plastic surgery—so remarkable, in fact, that the plastic surgeon who was advising the author said it couldn't be done.

"I've got the most modern equipment available," he explained. "And I know *I* couldn't get those results—not with all my equipment and the county hospital's equipment put together."

In a case of this sort, major revisions may be necessary. Sometimes, though, Moser manages to satisfy his doctor-critics by making only minor changes.

For instance: The leukemia epi-

sode originally wound up with a nurse asking the doctor, "Should I tell Mr. Carroll that his wife died?" Dr. Styner's reply was an abrupt, "No, tell him his baby lived."

Soften Blows

This was a good TV punch line, the committee conceded, but it also made the doctor seem hard-hearted. So, in the final version, Styner added: "Tell him I'll be out in a minute to talk to him."

Once the final script has been approved, the actual filming begins. Like its prototype, "Dragnet"—a TV drama that uses the files and facilities of the Los Angeles Police Department—Medic stresses real-life locations, as well as situations. One of the main "shooting" locations is the huge Los Angeles County General Hospital. But some of the smaller hospitals and clinics in the city have been used, too. (Only occasionally does a private physician's office figure in the plot.)

Consultants Help

During the filming, there are always at least two M.D.s on the set. Both of them are experienced specialists. Both are particularly interested in the subject currently being handled. And both act in a consultative capacity.

Between them, the two doctors give advice on everything from lighting angles to casting. "We're especially careful not to permit an Alcatraz type to play a member of

the medical profession," one consultant says.

For the most part, *Medic* is acted by professional actors and actresses. But real doctors and nurses often play "bit" parts. For instance, if the script calls for a character to do something that couldn't be safely entrusted to a layman—like delivering a baby—a licensed M.D. naturally acts as stand-in.

After the shooting's over, medical men get still another chance to weed out technical errors. The entire committee is invited to an evening session (which may last four or five hours), during which the raw films are gone over.

"What may have looked good in

the final script sometimes looks awful on the screen," Jim Moser points out. As a result, retakes are fairly common. When the rough film has been O.K.'d, a polished version is put together with musical score, synchronized sound, etc. Only after the committee accepts *this* version does the medical society officially approve the episode.

Despite the drawn-out process of authenticating each film, mistakes sometimes slip through. Luckily, most of the boners so far have been small enough to escape the notice of all but a few sharp-eyed doctor-viewers.

Once, for example, a character was shown with a stethoscope stuck

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"Well, then, can you give me something to take it out of my mind?"

in his ears backward. Another time, an actor-surgeon diligently scrubbed up for an operation—and promptly recontaminated himself by toweling his arms up and down instead of only once in a single direction.

Though mistakes of this sort are rare, *Medic* does sometimes have to sacrifice its highly prized realism to TV's code of ethics. The leukemia show is a case in point.

Some Taboos

In that episode, the climax came when Dr. Styner tried desperately to get the dead woman's baby to start breathing. As one real doctor remarked, the hero might have saved the TV audience minutes of suspense by sticking his thumb up the baby's anus—"which any sophomore medical student knows will make a baby breathe faster than anything."

Obviously, not even Moser's passion for realism would have got *that* past the network's censors.

To its credit, *Medic* has achieved a consistently high level of honesty. In another episode, when an obstetrician interviews a pregnant woman, he comes right out and asks, "When was your last period?" Network officials conceded that such a question would cause some maidenly blushes among the TV audience. Yet they decided that the question had enough bearing on the "case in point" to be allowed to stand.

Almost everybody who discusses

Medic compares it with *Dragnet*. There's certainly a lot of similarity between the two shows. And this is scarcely surprising, when you consider that Jim Moser got his TV training as a writer for the older series. But from the viewpoint of medicine's public relations, the similarity is often a source of embarrassment.

Take Richard Boone, who plays the role of host-narrator Konrad Styner: He's obviously a hangover from Moser's *Dragnet* days. Boone, in fact, played the police captain in the movie version of *Dragnet*; and some critics have commented that he makes a more convincing cop than physician.

As Dr. Styner, Boone is consistently tough-sounding and poker-faced. "A doctor can't function when he gets emotionally involved," he explains. But while there may be much truth in this statement, many a doctor wishes that the *Medic* star would learn that a person can be unemotional without looking like a ramrod.

Then, too, Boone and his fellow *Medic* doctors sometimes lapse into the kind of monosyllabic dialogue that seems more suited to a police station than to a doctor's office. The Los Angeles society's TV committee constantly finds itself weeding out expressions like "No, Ma'am, I don't," and "It was 10:10 A.M. Friday, Nov. 27."

If *Medic*'s physicians often seem cold and thick-skinned, there's rea-

son for it: The idea behind the series hit Jim Moser in 1949, when he was adapting some "Dr. Kildare" movie screenplays for radio. He conceived of Medic's tough-grained realism as an antidote to the flabby sentimentality of Kildare.

In order to learn more about the realities of medicine, he began to bone up on medical terminology and techniques. He visited medical libraries. He hung around hospitals. He talked to every doctor he could meet.

Then, early in 1953, the young Dragnet and Kildare alumnus took his new idea (and a sample script) to the Los Angeles County Medical Association. He offered the medical society both script and sponsor approval; and he promised to interpret faithfully the doctors' side of all doctor-patient relationships.

The Doctors Approve

The medical men pondered the invitation for seven months before finally agreeing to provide the show with technical assistance and official sanction. Soon afterward, N.B.C. and Dow Chemical also got into the act.

Now, more than a year later, Medic has established itself as the first consistently good TV drama to reflect medicine's views. As far as authenticity is concerned, it ranks with the Smith, Kline & French discussion-type series, "March of Medicine"—another N.B.C. program.

In a way, its authenticity results

from its efforts to let the public know about *good* medical technique—not necessarily about optimum technique. It's concerned simply with showing how a given doctor handles a given patient's care with the facilities at hand. And this avoidance of the sensational, the over-slick, and the over-imaginative helps to keep it lifelike.

Medic's modesty is actually a convenient thing for the producers, too, since it gives them an "out" in case a doctor-hero happens to overlook one of the very latest procedures. And physicians in general certainly approve of this reluctance to play up optimum techniques.

'Miracles' Are Out

As a matter of fact, the Los Angeles doctors tend to discourage suggested episodes featuring "miracle" cures. A given technique, they point out, may be commonplace in a metropolitan area like Los Angeles; yet it may still be out of the question for the small-town practitioner. And the program would defeat its purpose if it left the ordinary family doctor open to embarrassment.

Even so, some doctors complain that the series puts too much stress on unusual cases: leukemia, heart stoppages, and the like. And a number of physicians are wondering, too, whether the public will continue to lap up the diet of ungarnished realism that Medic offers.

Dr. E. Vincent Askey, Los An-

geles surgeon and vice speaker of the A.M.A. House of Delegates, raises the question in these words:

"I thought the show about leukemia was marvelous, technically and theatrically speaking. But my patients and nurse don't agree with me. For them, an unrectified tragedy at the end of a play is more than any television audience should be expected to endure."

Can Laymen Take It?

A Pasadena internist, Edward C. Rosenow Jr., comments in a similar vein:

"I can bear to see stark realism on my living room screen because I live with it day after day. It's another matter for my wife and kids, who can't bear to sit and watch a woman cringe under the news that she has an incurable ailment. On any other show, the physician-hero would find that the villain had switched X-rays and that the patient was going to live, after all. But on *Medic*, once the prognosis is negative, you know it's going to stay that way."

A few TV critics agree that *Medic* is a strong mixture for the average layman to take. Faye Emerson, for one, admits that she and her husband, pianist Skitch Henderson, were "dissolved in tears" after the first episode. And Harriet Van Horne, of the New York World Telegram and Sun, finds *Medic's* approach "a shade too terrible, too agonizing."

John Crosby, of the New York

Herald Tribune, says he got a "horrid fascination" out of watching the first show. "I'm not at all sure I was enjoying myself," he concedes, "but I couldn't tear myself away. This, I suspect, will be the lure of the show. Hospitals, like police stations, have strong audience appeal, as witness all the soap operas . . . The idea is to tear their hearts out; and, believe me, this is a show that can do it."

Crosby may be right. Still, if "tearing their hearts out" is the key to *Medic's* success to date, it's odd that the show has gone over so well with the nation's doctors. That it *has* gone over well is proved by testimonials galore.

Endorsed by Doctors

"This is the greatest public relations work a county medical society has ever done for organized medicine," says the vice president of one large society. "I think the creator of this series should have a plaque and a bust of himself in our Hall of Fame."

A small-town G.P. states his reaction more conservatively, but with no less enthusiasm: "This program is a wonderful rarity among medical features, because it shows the profession as we are—or, at least, as we should be."

It would seem that, with few exceptions, America's doctors like *Medic* about as well as anything that has yet come over the air waves.

END

How Receipts Can Boost Cash Collections

One form features a summary of the patient's account; another form includes an itemized charge slip. Here's how they can help you

By Lois Hoffman

● More and more doctors are discovering what many businessmen learned long ago: Giving receipts is good business practice.

Properly handled, the receipt may well stimulate cash collections, for it helps create the impression that on-the-spot payment is accepted as a matter of course. Then, too, the receipt serves as a tangible "thank you" to the patient; and it assures him that his payment has been recorded in a businesslike manner. (Incidentally, he may find the receipt useful for his income tax records, too.) And, finally, the stub or carbon retained by the doctor's aide provides a double check on her financial records.

When receipts are given for every payment—whether received from the patient in person or by mail—the duplicates may be used to verify all entries in the daybook. But many physicians find them valuable mainly as a record of cash payments made during the rush of office hours, when slip-ups in bookkeeping are most likely to occur.

There are various kinds of receipt forms, of course. But we think you'll be especially interested in the two illustrated on the following pages, since they're well adapted for use in doctors' offices. [MORE→

RECEIPTS CAN BOOST CASH COLLECTIONS

GEORGE J. LUTTRELL, M.D.
88 NORTH VINE STREET
EVANSTON, ILLINOIS

DATE Dec. 10, 1954

RECEIVED OF Albert Appleton \$ 5.00

Five and 00/100 DOLLARS

ACCOUNT TOTAL \$ 32.00

AMOUNT PAID 5.00

BALANCE DUE \$ 27.00

Thank you!

L. B. Evans



THIS RECEIPT SUMMARIZES THE PATIENT'S ACCOUNT

Reminder of balance due is a feature of this standard form, resembling those sold by most stationers. (For a few dollars more, your printer will make up pads of similar forms, with individual variations to suit your practice.)

The receipt book, so labeled, is generally kept on the aide's desk in plain view. As the patient prepares to leave, the secretary asks whether he requires another appointment. "The fee for this visit is \$5," she says pleasantly, one hand on the receipt book. Sometimes she may want to add: "You can pay now, if you wish." If the patient does pay, the aide makes out his receipt, keeping a carbon copy for her files. Note that the "Thank you!" is handwritten, rather than imprinted, for a more personal touch.

THIS RECEIPT IS ATTACHED TO A CHARGE SLIP

When introduced in one medical office, this form soon boosted monthly on-the-spot payments from less than \$200 to about \$1,600. Here's how it's used: At the close of each visit, the doctor notes on the slip the services he has given, then asks the patient to leave the slip with his receptionist. The patient is sure to note that prominent word, "RECEIVED."

PLEASE LEAVE THIS SLIP WITH RECEPTIONIST

DATE Dec. 10, 1954

PATIENT'S NAME Albert Appleton

OFFICE CALL		✓	4.00
HOURS CALL			
DORMERY			
INJECTION	Penicillin	✓	1.00
DRUGS			
LABORATORY	Blood count	✓	5.00
TOTAL			10.00

GEORGE J. LUTTRELL, M. D.

88 NORTH VINE STREET
EVANSTON, ILLINOIS

DATE Dec. 10, 1932

RECEIVED OF Albert Appleton \$ 10.00

Ten and $\frac{20}{100}$ ——— DOLLARS

L. B. Evans

Thank you!

If he pays cash, the aide gives him the filled-in receipt, keeping the upper portion of the form for her files. If no payment is made, she keeps the entire form. Each day, cash receipts (not including payments by mail) should add up to the sum of the totals on the charge slips from which the receipt forms have been torn off. END

KMD

These M.D.s Have Own 'Major Medical' Plan

They wanted a chance to buy 'catastrophic' illness insurance on a group basis. And they got it

By Emerson F. Long

● Dr. Smith lives in Arizona, Dr. Jones in Connecticut. Both men are general practitioners. Both have families. Not long ago, they both bought major medical expense insurance policies.

The two policies have the same face value (\$5,000 maximum benefit for each illness) and the same deductible amount (\$500). But Smith's contract in Arizona contains a 25 per cent co-insurance clause, while Jones' is only 20 per cent. Also, Smith's annual premium is \$163, while Jones in Connecticut pays only \$75.

Smith deliberately chose a plan with a high premium. He took it for granted that in paying more for major medical insurance, you're bound to get more. He was not entirely right.

Let's assume that illness strikes the families of both men and that, by coincidence, the total medical bill of each comes to \$6,750. Of this sum, the Arizonan has to pay \$2,062.50 out of his own pocket. His Connecticut colleague has to pay only \$1,750.

Thus, though both men get their money's worth from their policies, Dr. Jones in Connecticut certainly has the better deal. This is especially true since the insurance company, after paying its share of his bill, cannot then

cancel his policy, as might the Arizona doctor's carrier.

About a dozen insurance companies now sell major medical expense coverage to individuals; and few of them would cancel a policy peremptorily. Yet, with rare exceptions, their contracts give them the right to do so.*

Jones has had an advantage over Smith from the beginning. Since he lives in Connecticut, he was able to buy comparatively inexpensive, noncancelable insurance under a group plan arranged by his state medical society.

The Connecticut doctors' plan has been in effect for nearly three years—since April 15, 1952. Before that date, physicians who wanted so-called catastrophic coverage had to buy it on an individual basis. But a number of them felt that it ought to be possible to arrange for a group plan; so the state society set out, in pioneer fashion, to see what could be done.

The medical men took their problem to the Commercial Insurance Company of Newark, N.J. There was born the Professional Men's Group Catastrophic Medical Expense Plan, sponsored by the Connecticut State Medical Society and underwritten by the Newark company.

The program has proved an "unqualified success," says Dr. Creighton Barker, the society's executive secretary. "Many hundreds of our total membership of 2,900 are now covered by it. In fact, better than 50 per cent of all eligible members have subscribed."

Obviously such a plan must offer something pretty special, to appeal so strongly to so many doctors. Here, briefly, are its distinctive features:

¶ Policies are noncancelable, except for nonpayment of premium or on withdrawal from the Connecticut State Medical Society.

¶ Policies are issued to and renewable for—doctors

*For a full discussion of this subject, see "How They're Insuring Those Major Medical Expenses," MEDICAL ECONOMICS, November, 1954.

up to the age of 70 (most major medical policies have an age limit of 60 or 65).

¶ The premium is comparatively low (\$75 covers all eligible dependents; premium range of twelve other companies: \$55-\$180).

¶ The insured need pay only 20 per cent of his expenses above the deductible amount (for most policies sold on an individual basis, this co-insurance requirement is 25 per cent).

Are Connecticut's physicians satisfied with what they're getting for their money? Listen once more to Dr. Barker:

"Claims actually paid give ample testimony to the need for this kind of insurance and to what it is accomplishing for our members. Several claims have already been settled

in the amount of \$5,000. The average payment on claims has been \$853, proving clearly that the plan is of financial importance to the individuals affected."

The major medical expense group plan is working so well, in fact, that some Connecticut physicians have wondered why their colleagues in other states haven't followed their lead. One good reason is that most doctors haven't yet heard of the Connecticut program.

The idea is so new, in fact, that the Commercial Insurance Company of Newark, N.J., says it still considers the Connecticut plan "experimental." But it seems very likely that when the experimental phase finally ends, doctors elsewhere will be eager to take advantage of similar insurance plans. END



© MEDICAL ECONOMICS

Fine Points of the Law on ABORTIONS

The courts interpret the law so strictly that even the doctor who feels himself justified in recommending a therapeutic abortion can have made a grave error, says this lawyer

By Harold Raveson, LL.B.

● The average woman who's healthy and who wants to be rid of a pregnancy knows that her family medical adviser won't do an abortion.

But what good is an adviser if he won't give advice? So she presses the point; and, as a result of her urging, the physician *may* be tempted to mention that he's heard of a certain Dr. Blank, with an office on Park Street, who might help her out.

Is the well-meaning family doctor who gives way before such pressure committing a crime? The answer, in many states: Yes. For it has been held that "mere advice and information are considered as completing the offense, even without an overt act."

Indeed, in one case where the woman died, a court ruled: "If [the doctor] merely urged or counselled, he would be an accessory before the fact and would still be guilty of murder."

Usually the physician knows perfectly well whether he's advising a criminal abortion or a therapeutic one. The essence of the crime is *intent*; and to every doctor his own intent is clear-cut.

[MORE→

He may, of course, rationalize his advice in various ways: The patient is a tired, exhausted woman and the strain of labor might wreck her health; she has threatened suicide unless aborted; if her family doctor won't send her to a competent practitioner, she may be permanently harmed by some quack. Yet, no matter how he rationalizes, the physician knows what he's doing when he does it.

The woman may promise to keep the source of her information forever secret. But let the slightest trouble arise—an infection, a change of mind by the husband, an accidental disclosure—and the victim or her family will promptly point the finger at the doctor who started things.

While an occasional statute uses the words "pregnant woman" in defining the crime, a doctor can generally be convicted even if the woman *wasn't* pregnant. The crime has only two chief components: the intent and the act.

Take a case in point: The doctor isn't sure whether the woman is pregnant. He prescribes an ecobolic drug, hoping that it "will bring her around." As it turns out, she is not pregnant and the drug makes her a little sick. In retaliation, she sues the doctor for civil malpractice.

Whereupon it becomes known that the drug was prescribed for the purpose of inducing abortion. Next day the doctor is visited by a man from the district attorney's office.

Medicine may distinguish be-

tween abortion and miscarriage, but the law draws no such line. An attempt to interrupt a pregnancy is considered an abortion. And if the motive is anything short of the necessity for saving the mother's life, it's considered criminal abortion.

In some states, an abortion rates as "therapeutic" if needed to preserve the health of the mother. But in many jurisdictions, an abortion is lawful only if necessary to save her life. The physician must be ready to show that if the pregnancy had continued, death would probably (not just *possibly*) have resulted; and that emptying the uterus was the only reasonable method of saving the patient's life.

Chances are that the doctor may safely recommend an abortion if the woman has a disease of the heart (or any other organ) that would tend to cause her death under the strain of labor. Or he may do so if she has a toxemia or other complication that would ordinarily be regarded as a serious, life-threatening disorder and that would properly be treated by halting the pregnancy.

But that's as far as the legal limit of safety extends. Beyond it, the physician may well find himself out of bounds. For example:

A woman threatens suicide unless aborted. The doctor believes she means it and advises an abortion. He reasons that the alternative would be the patient's self-inflicted death. Is the physician in the clear?

He is not. What the law means by

"probable death" is a fatality resulting from the pregnancy or delivery.

Take another example:

Suppose a family doctor knows that the shame of pregnancy in a certain sensitive, unmarried girl would plunge her into a depression—perhaps into a severe psychotic breakdown. Is an abortion legally justified?

The answer is still no. A doctor who advises an abortion under these circumstances may find himself serving a long prison term.

Must Be Life-Saving

What if the woman has a chronic, intermittent disease—for instance, asthma, multiple sclerosis, or migraine? Pregnancy and labor are strains that might aggravate the illness; but can it be proved that an abortion would save life? Probably not. So there's no legal justification here either.

One authority puts it this way: "Induction of abortion is legally justifiable whenever there is such mechanical obstruction that the birth of a viable child is impossible or whenever the mother is suffering from such serious disease that her life is in peril and can be saved only by interruption of the pregnancy."

The secrecy or overtness of an abortion is a matter of considerable evidential importance. That's why a physician who knows what he's up to avoids doing an abortion in his own office.

Instead, he takes the patient to a

reputable hospital, has a consultant write his conclusions on the clinical chart, conforms to the hospital's rules, and does the abortion in the operating room with a full staff of assistants and nurses present. Since he has followed this procedure openly, it will be hard to prove that he had any intent to violate the law.

There are sometimes hard decisions to make, of course. For instance, an ethical practitioner may find himself in a bad spot if a woman is brought to his office bleeding after an incomplete abortion done elsewhere. He may find it necessary to finish emptying the uterus himself; yet he knows this is the kind of situation that can easily arouse suspicion.

So what does he do? He notifies the police, and he sends for an obstetrical or gynecologic consultant.

It may seem cruel to report this sort of thing to the police. It may lead to legal and social difficulties for the woman. It may be construed in some quarters as a breach of the doctor-patient relationship. But for the physician, it could be a lot more cruel if he failed to call the police and if the woman later died.

Remember this: No malpractice insurance policy gives any legal or financial protection if the doctor is indicted for criminal abortion. The best assurance against liability is a fully documented hospital clinical record—or a firm lateral shaking of the head when asked to recommend an abortionist.

END

What's Happening to Malpractice Rates

Though coverage costs more than ever in some states, it's leveling off—thanks mainly to the National Bureau of Casualty Underwriters

By W. Clifford Klenk

● Malpractice rates are still on the rise. Across the country, they're roughly 10 per cent higher than they were two years ago. And in certain areas—notably the Far West—the rate of climb seems jet-propelled.

Even so, there are—at long last—a few bright spots in the gloomy picture. In more than a third of the nation, for instance, major-company rates have apparently stopped spiraling. And in some respects they've actually dropped.

None of this could have happened, of course, without the average doctor's acute awareness of the malpractice problem and his individual efforts to solve it. But much of the credit for the partial stabilization of rates belongs also to the National Bureau of Casualty Underwriters.

It was about two years ago that some thirty stock insurance companies got together, under bureau auspices, to work out a standard malpractice policy form and to set uniform rate schedules. Naturally, since the malpractice problem differs from state to state, it was impossible to fix a single national rate. But at least the bureau was able to set a standard rate within every state.

This was no mean accomplishment. By standardizing

the policy form, the stock companies did away with much of the confusion that policy-shopping medical men used to face. By pooling their risk experience, the companies were able to give doctors the most realistic rates yet devised. And by setting an example, they naturally influenced rate-making policies of non-bureau companies.

Now, with two years of working experience behind them, the casualty underwriters have published brand new malpractice rates. The full set of up-to-the-minute figures appears on the accompanying map.

How do these new rates compare with the old ones? Generally, they're higher: The average national base rate for non-surgeons is about \$44 for \$5,000/\$15,000 limits—some 10 per cent more than in 1952. There's nothing spectacular about this change; but a state-by-state comparison of new and old rates uncovers some surprising facts. For example:

¶ In three states, rates since 1952 have doubled. The Oregon base rate, which was \$45 in 1952, is now \$90. In Illinois and Georgia, the jump has been from \$25 to \$50.

¶ In five states, base rates have climbed 60 to 75 per cent. In metropolitan Northern New Jersey, they're up from \$35 to \$60 (71 per cent); in the rest of New Jersey, up from \$20 to \$35 (75 per cent). Virginia rates went from \$30 to \$50 (67 per cent); Maryland's rise was from \$25 to \$40 (60 per cent); and Montana and Nevada rates rose from \$50 in 1952 to \$80 today (60 per cent).

¶ In California, a well-known sore spot, the rise wasn't quite so notable (state-wide, the average increase was about 40 per cent); but base rates have reached a record-breaking \$130 in the San Francisco-Alameda and Los Angeles areas, compared with \$110 in the rest of the state.

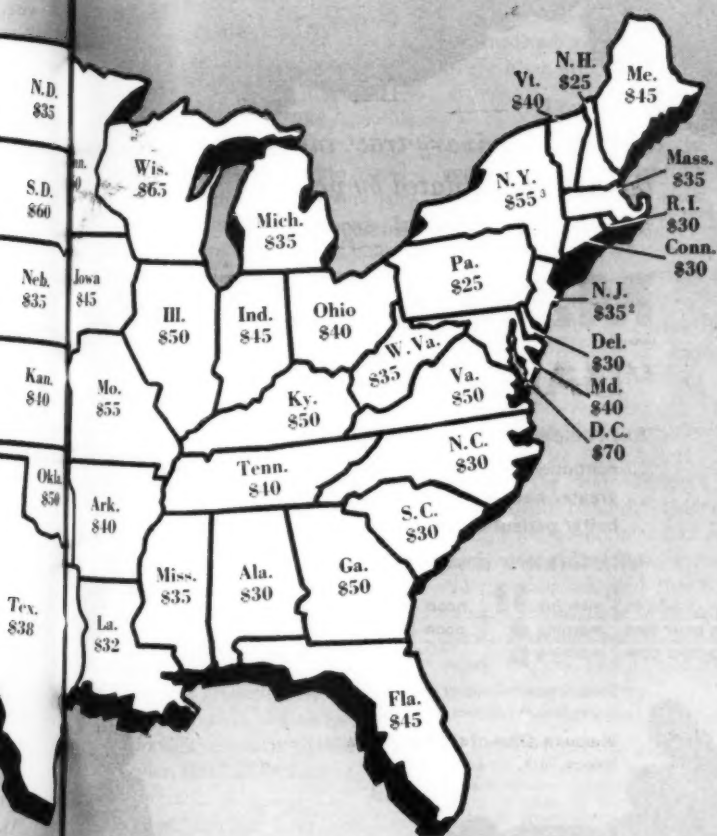
¶ New York State, by contrast, [MORE TEXT ON 155]

New Malpractice Rates



FOR NON-SURGEONS, with policy limits of \$5,000/\$15,000, insurance companies that are members of the National Bureau of Casualty Underwriters now quote these annual rates, by state. To determine the cost of higher-limit policies, multiply the base rate shown on the map by 1.55 (for \$15,000/\$45,000 coverage) or 1.71 (\$25,000/\$75,000) or 1.89 (\$50,000/\$150,000) or 2.06 (\$100,000/\$300,000).

Rate From Coast to Coast



¹San Francisco, Alameda, and Los Angeles counties, \$130; rest of California, \$110. ²Bergen, Essex, Hudson, Passaic, and Union counties, \$60; rest of New Jersey, \$35. ³New York City, and Nassau and Westchester counties, \$75; rest of New York, \$55. Source: National Bureau of Casualty Underwriters. Map copyrighted, 1954, by Medical Economics, Inc., Rutherford, N. J.

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adults	morning 	noon 	evening 	0.5 Gm.
children over five	morning 	noon 	evening 	0.25 Gm.
infants under one	morning 		evening 	0.25 Gm.

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has held its own. It's one of seventeen states where rates haven't budged since the bureau came into the picture. New York City metropolitan rates remain \$75, while the upstate base cost of malpractice insurance stays at \$55.

[In one state—Indiana—bureau rates have actually declined. The base rate was \$60 in 1952; now it's \$45—a dip of 25 per cent.

[One final country-wide development: The bureau-company surcharge rate has been lowered. In 1952, for example, the added charge for partnership liability or for physician-employee coverage was half the base rate. It has now been reduced to one-third the base rate.

The Other Carriers

Of course, not all the companies that write malpractice insurance belong to the National Bureau of Casualty Underwriters. One or two stock companies remain outside the fold; and so do the mutual companies—some of which handle large group malpractice policies.

Two organizations that fill special niches in U.S. malpractice insurance also have no affiliation with the bureau. One, Lloyd's of London, is the only foreign concern in the field. The other, Medical Protective, is the one domestic company that deals only in malpractice insurance.

But bureau rates *have* affected the rates of many of these non-bureau companies. For instance, take a look at the mutuals:

In Montana, to mention one area, almost all the mutual companies have stopped writing malpractice insurance rather than compete on bureau terms. Apparently, the mutual companies feel that Montana's bureau-fixed rate, while comparatively high, still isn't high enough.

Lower Rates

In certain other areas, the mutual companies are undercutting bureau rates. The San Francisco doctor who must pay \$130 for bureau-company coverage, for example, can buy a policy from American Mutual Liability for \$85. Similarly, St. Paul-Mercury Indemnity currently writes malpractice policies in Indiana for about 15 per cent less than the bureau companies charge.

It's yet another story in New York State, where Employers Mutual handles the state society's group plan. Until recently, this carrier, along with most others, had one rate for physicians, another for surgeons. Now, it has adopted three sets of rates: one for men who do no surgery, a second for those who do minor surgery, and a third for those who do major surgery.*

Why the three sets of rates? Evi-

* Under the heading of major surgery, Employers Mutual includes anesthesiology; operative obstetrics; cutting or probing into any cavity or sinus of the head, neck, throat, abdomen, spine, anus, or genital organs; incision or excision of breast, thyroid, or other gland; open orthopedic procedures; nerve and vascular surgery; removal of excess adipose tissue; skin grafts; surgical biopsies; and cystoscopy. Minor surgery includes uncomplicated obstetrics, transfusions, and any surgical procedure not classified as major.

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MALPRACTICE RATES

dently, Employers Mutual is interested only in certain types of business. It offers rates almost as good as the national bureau's to metropolitan doctors who do no surgery; and it offers rates lower than the bureau's to upstate men who do no surgery. But, as the following figures show, it makes no effort to offer low rates to doctors who do major surgery:


	Metro- politan	Upstate
Major surgery	\$226	\$119
Minor surgery	126	65
No surgery	76	40

Something of a newcomer to the U.S. malpractice field, Lloyd's of London has been doing malpractice business here for only a few years. It now writes several group policies, including one for the American College of Physicians (bought by 1,200 of A.C.P.'s 8,000 members).

Low-Rate Companies

Generally speaking, low rates are its chief lure. In New York State, for instance, Lloyd's rates are far below those of Employers Mutual and of the bureau companies. (In California, though, its rates are the highest of any now offered.)

Low-cost coverage is also the chief attraction of Medical Protective. This company is the veteran among malpractice insurers; it has been in the liability business for fifty-five years. Average base rate for Medical Protective coverage is about \$26. This helps explain why



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MALPRACTICE RATES

the company probably has more doctor-clients than any other concern in the field. Three facts about Medical Protective should be noted, however:

1. It operates in just eighteen states;

2. It won't ordinarily write a policy with limits higher than \$5,000/\$15,000; and

3. It won't ordinarily insure men in certain high-risk specialties (X-ray therapy, plastic surgery, orthopedic surgery, etc.).

More Stability Ahead?

All in all, it's clear that there are still some critical areas on the U.S. malpractice map. But it's evident, too, that malpractice insurance rates in *most* places don't pose too pressing a problem.

In New England, where basic coverage by a bureau company costs, on the average, less than \$35, few doctors find cause for alarm. Nor do costs seem inordinately high in twenty-four other states where

\$5,000/\$15,000 coverage is still available for no more than \$50. Even in the high-rate areas, the National Bureau of Casualty Underwriters seems to be playing the long unfilled role of stabilizer.

Just the same, few medical men expect that the bureau, Lloyd's, or any other agency will be able to perform a miracle and send malpractice rates plummeting. "If anything," says one medicolegal authority, "we can expect them to stay high and perhaps go higher." Among his reasons for this conclusion:

"The number of suits keeps growing, so there are more settlements, too. The low value of the dollar has increased the size of the average settlement. Lawyers are more ready than ever to go to court against doctors. And at the bottom, there are the many, many patients who are disenchanted with the modern physician. Until we solve *that* problem, we can't expect to reverse the direction of malpractice rates." END

Hot Shot

● I'd been asked to see an elderly gentlemen, suffering supposedly from a urinary tract infection.

In the course of the consultation, I asked him if his urine burned.

"Well, to tell the truth, Doctor," he replied earnestly, "I haven't tried to light it."—ARMAND L. RUDERMAN, M.D.

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References: 1. Antibiotics & Chemotherapy 2:55, 1952. 2. Scientific Exhibit, Norristown State Hospital. Data to be published. 3. A.M.A. Exhibit, June 1951. 4. Am. J. Physiol. 166:639 (Sept.) 1953.

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MINERALS		
Calcium Gm.	.021	.021
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VITAMINS		
A I.U.	20	10
B ₁ mg.	.075	.05
B ₂ mg.	.02	.04
Niacin mg.	.22	.22
C mg.	35	41

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If Your Patient's Afraid To See a Psychiatrist

The main reasons why people balk at psychiatric care, plus some counterarguments you can use

By Carl L. Kline, M.D.

● They tell of the family physician who was threatened with a lawsuit and almost talked out of town.

What had he done—set a fracture improperly? Or written the wrong dosage on an Rx blank?

No, indeed. He had merely tried to refer a neurotic woman to a psychiatrist; whereupon she had cried out in anguish to all who'd listen that her nasty, mean doctor had said she was crazy.

This pinpoints a mounting problem for many a G.P. today: how to suggest a psychiatric referral without alienating the patient.

Sophisticates among your clientele are likely to take it with good grace when you broach the matter like this: "Since you're in sound condition physically and since your trouble seems to be a basic emotional difficulty, I think a psychiatrist could do more for you at this point than I can."

But in the mind of a less knowing and intelligent patient, even a remark worded as mildly as this may conjure up a menacing specter. So such a patient is quite apt to hit the roof: "Why should I go to that kind of doctor? I'm not crazy!"

Because such reactions are common, you must quickly

consider

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PSYCHIATRY

make it clear that psychiatrists' offices are not used for treating "crazy" people. You can point out that most people who visit a psychiatrist these days do so to get help on common, everyday emotional problems.

Sometimes the stumbling block is not prejudice against the specialist but fear of high fees. This is your cue to point out that the patient would doubtless expect to pay several hundred dollars for a surgical operation to improve his condition physically. A course of psychiatric treatment, you can add, should be worth a comparable amount, since it will make him feel better mentally (and since, incidentally, it will probably be less painful and dangerous and will demand a lot more of the doctor's time). The psychiatrist, before starting work, should, of course, give the patient the best estimate he can of what the actual fee will amount to.

It Isn't Analysis

To rationalize the postponing of psychiatric care, some patients say they've heard that successful psychotherapy requires extended daily interviews. They complain that they can't possibly afford all that time. To which the practitioner who knows the score replies that it's highly unlikely that the patient will need that much treatment.

The doctor can point out that it's generally possible to work out a convenient schedule with the psychi-

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*T.M. Reg. U.S. Pat. Off.

atrist. And he can make it clear that psychiatric treatment needn't entail extended psychoanalysis.

He may well add that psychiatrists find they can often help patients by seeing them only once a week. In addition, the psychiatrist can usually fit his appointments to patients' time-tables better than the surgeon, since he doesn't have to anticipate emergency calls or reserve time for hospital visits.

Explaining Why

You'll often hear patients say: "I'm not neurotic. I don't just imagine these pains. I really have them." Nothing arouses more resentment than a doctor's implication that the patient's symptoms are imaginary. So a safe answer may well be something like this:

"I know your pains are real. But examination shows nothing wrong physically in the area affected. The fact is, your pains are caused by nervous tension. It's precisely because there is no physical disease present that I expect you to get well." And you can further reassure the patient by giving him a few examples of how emotional tensions can produce physical symptoms.

This sort of reassurance serves two purposes: It relates the need for psychiatric care to the physical symptoms. And it implies a favorable prognosis.

When you bring up the subject of psychiatry, a self-assured patient may object: "Why, I'm not nervous;

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"...good correlation with the amount of sugar determined with Benedict's quantitative method."*

"Mistakes...less likely with Clinitest."*

*Cook, M. H.; Free, A. H., and Giordano, A. S.: *Am. J. M. Technol.* 19:283, 1953.

Ames Diagnostics
Adjuncts in clinical management



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"... and be sure to take your VITAMINS!"

Hepatic disease strikes at the patient's nutritional well-being by interfering with vitamin intake, absorption, and utilization. Adequate vitamin supplementation goes a long way to maintain and improve the patient's nutritional reserves.

MERCK & CO., INC., Rahway, N. J.—as a pioneer manufacturer of Vitamins—serves the Medical Profession through the Pharmaceutical Industry.

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*No other
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ASK FOR IT BY NAME—
MAKE SURE YOU GET IT!

You're 6 ways safer with "Prestone" brand anti-freeze

1. Contains no alcohol. Vapor from "PRESTONE" anti-freeze solution cannot be ignited by a spark or cigarette.
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I don't have a nerve in my body."

An adroit way to meet this objection is to say:

"Yes, I know that may be your impression. But, actually, without realizing it, you *are* nervous. If you showed it—if you gave vent to your nervousness—it would release the pent-up pressure. Instead, you have a tendency to hold back and keep your feelings bottled up. That's what makes your heart pound [or causes muscle cramps, or pours acid into your stomach, or whatever the psychosomatic explanation]. A psychiatrist can sit down with you and help you to work out all these emotional factors."

Another common line of resistance is based on a sense of shame: "If I'm seen walking into a psychiatrist's office, my family and friends will think I'm wacky."

'It's Not Shameful'

That's the family doctor's opening to explain that "Most intelligent people today accept the role of psychiatry. Besides, the specialist doesn't have any distinguishing mark on his sign—just a plain M.D. Generally, the only people who know he's a specialist in nervous disorders are his other patients."

In spite of all your reasoning, some patients will still plead for medicine to make their symptoms disappear. One way of meeting this is to say: "I can do that easily enough. But you're too intelligent to be satisfied merely with some pain-

killing drug. Nothing to date has helped you. Why not get to the bottom of the trouble once and for all?"

It's well to remember that psychiatrists are available for consultation just as other specialists are. They know that in some cases the family doctor can get further with the patient than they can. Often the psychiatrist's main function is to give practical suggestions on handling the various kinds of emotionally troubled patients.

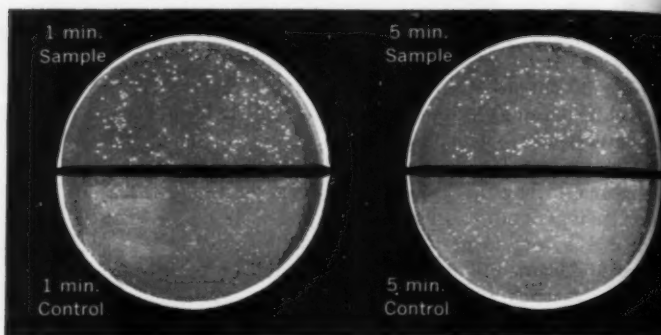
The referring physician should expect the psychiatrist to supply regular reports on each such patient referred. These reports will throw a lot of light on what makes people act the way they do.

END



"I ask her if it's chronic or acute and she asks which is worse and I say acute so she says, well, that's what I've got."

Photographic evidence of Drilitol's anti-bacterial action against a combined culture



EXPERIMENT Drilitol's antibacterial agents, gramicidin and polymyxin, were dissolved in 10 cc. diluting fluid. 2 cc. of this solution, which was a much lower concentration of the antibiotics than is provided by 'Drilitol', were combined with 8 cc. of a combined *Hemophilus influenzae*-*Staphylococcus aureus* broth culture.

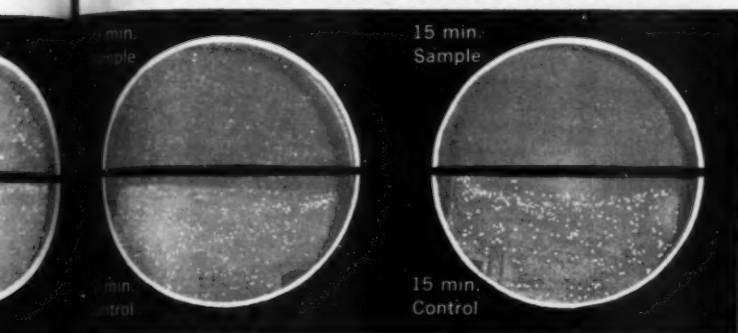
control 2 cc. of the diluting fluid alone were combined with 8 cc. of the *Hemophilus influenzae*-*Staphylococcus* broth culture.

method Samples were taken from each after 1, 5, 10 and 15 minutes respectively, and streaked on chocolate agar. Photographs were taken after the plates were incubated overnight at 37° C.

RESULTS *Hemophilus influenzae*—total bacteriostasis in less than 1 minute.

Staphylococcus aureus—marked bacteriostasis within 15 minutes.

ti- GRAM-POSITIVE STAPHYLOCOCCI AND
lture GRAM-NEGATIVE HEMOPHILUS INFLUENZAE



polymyxin, ec. of this ion of the combined -Staphylo- with 8 cc. of th culture. 15 minutes otographs overnight at less than within 15

'Drilitol'—the most widely prescribed antibacterial intranasal preparation—offers the following advantages:

1. Two antibiotics—anti-grampositive gramicidin and anti-gramnegative polymyxin.
2. An efficient decongestant—Paredrine* Hydrobromide.
3. An effective antihistaminic to counteract allergic manifestations—phenylpyramine hydrochloride.
4. No risk of sensitization to—nor of engendering organisms resistant to—such widely used antibiotics as penicillin and the "mycins".

Available in two forms:

'Drilitol'† Spraypak'

and

'Drilitol' Solution

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F.

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'Spraypak' Trademark

THE EVIDENCE...

original and confirmatory

1951

Epidemic vomiting (acute infectious gastroenteritis or intestinal "flu") responds to EMETROL, "often with a single dose"...simple...physiologic.

Bradley, J. E., et al.: J. Pediat. 38:41, Jan., 1951.

In nausea of pregnancy—favorable response in 3 out of every 4 cases, usually within 24-48 hours..."free of annoying side effects...a safe and physiologic agent..."

Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311, Feb., 1953.

1953

1954

Recently reported "...particularly suitable for industrial dispensary practice, as well as for office and hospital treatment." Authors stress "safety, simplicity, economy..."

Tebrock, H. E., and Fisher, M. M.: M. Times 82:271, April, 1954.

WHY EMETROL WORKS EMETROL quickly relaxes smooth muscle, reduces rate and amplitude of contractions, and is effective in direct ratio to the amount used.

Levenstein, I.: Report of Echeron Laboratories, Roselle Park, N. J.

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**for rapid physiologic control of
nonorganic nausea and vomiting**

CAUTION: EMETROL must be taken *undiluted*. Forbid oral fluids of any kind for at least 15 minutes after each dose.

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Literature and sample on request

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I Index My Medical Reading

Have you ever searched in vain for an article you remember having read 'somewhere'? If so, you may want to try this physician's simple system for keeping facts at his finger tips

By Charles Harvey, M.D.

●One day, about four years ago, I was asked to lecture on heart disease in pregnancy before the internes and obstetrical staff of my local hospital. I remembered an article that had some good sidelights on the subject, so I started wading through the journals in my office.

Unable to find what I wanted there, I went into the basement where older issues were kept. But one look at the stacks of dust-covered copies was enough. I gave up.

This experience taught me a lesson: I resolved never again to waste valuable time scrabbling in dust heaps for half-remembered data. Next day I worked out a method of filing my medical reading systematically. It's really pretty simple:

When I want to save an article, I write the proper subject heading for it in the top right margin of its opening page. I also put a check mark after the title of the article in the table of contents. Then, when I've finished reading the journal, I leave it in my outgoing correspondence box.

My assistant takes over from there. She clips out each article I've checked, noting the name of the publication and date of issue in the top left margin of the first page. If the name and date are already printed on the page, she



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We've forgotten
about barbiturates
since we discovered
CLORTRAN

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In new CLORTRAN capsules you now can prescribe chlorobutanol, one of the safest and most reliable sedative-hypnotics, in a *stable* form heretofore unavailable.

Advantages: CLORTRAN is preferable to barbiturates because it is not habit-forming and produces "normal" sleep from which the patient can be easily and completely aroused, without hangover. Moreover, CLORTRAN is superior to chloral hydrate because chlorobutanol affords "chloral hypnosis without gastric irritation."¹ As Beckman remarks, "the profession would do well to use this drug more often in insomnia."

In addition, CLORTRAN actually exerts a soothing, spasmolytic influ-

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sedation hypnosis



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on request

ence on the gastric mucosa and muscularis.² It is specifically and directly beneficial in control of motion sickness.

Dosage: *Sedative-antispasmodic*, 0.25 Gm. 2 to 4 times daily. *Nausea or Motion Sickness:* 0.25 Gm., repeated in 30 minutes if necessary. *Hypnosis:* 0.5-1.0 Gm., ½ to 1 hour before retiring.

Contraindicated only in severe cardiac, hepatic or renal disease.

CLORTAN is supplied in golden-orange, soft gelatin capsules, 0.25 Gm. (3¼ Gr.) and 0.5 Gm. (7½ Gr.); bottles of 100.

1. Beckman, H. *Treatment in General Practice* (Saunders) 1948. 2. Krantz, J. C. & Carr, C.J.: *The Pharmacologic Principles of Medical Practice* (Williams & Wilkins) 1951.

CLORTAN

Sedative-Hypnotic-Antinauseant : Capsules Stable Chlorobutanol (Wampole)
Henry K. Wampole & Company, Inc., 440 Fairmount Ave., Phila. 23, Pa.

circles them (merely to keep her from forgetting this step).

She then staples the pages together and puts them in a large folder that bears the same subject heading. All these folders are filed alphabetically.

Asks for Reprints

Before she clips any item, she checks the back of the page. If, as sometimes happens, it's part of another item marked for filing, she may try to get a second copy of the periodical. Or, if it's not too big a job, she simply makes a typewritten copy of one of the pages.


Often, when two articles are back-to-back on a single page, I ask the author of one of them for a re-

print. (Incidentally, I've found that he's more likely to comply with the request if I write a letter—rather than a postcard—telling him why I want the article.)

What if information worth remembering turns up in my library reading? I make a notation like this: FRACTURES, aftercare: A. Zinovieff; "The Aftercare of Fractures"; Arch. Phys. Med. 35: 303-306, 1954.

All Are Indexed

If possible, I get a reprint of the item. If not, my secretary types the reference on a sheet of paper (letter-size, so it'll be easy to spot) and files it in the folder marked "FRACTURES, aftercare." We handle refer-



ANUSOL

hemorrhoidal suppositories

Fast and prolonged relief from itching and pain

WITHOUT ANESTHETIC or ANALGESIC DRUGS

WARNER-CHILCOTT

AGING CHANGES THE BONE PICTURE



TIBIA,
*magnified
sagittal
section*

Estrogen and androgen are vitally concerned with the preparation and recalcification of bone matrix, and this readily explains why declining sex hormone production associated with aging so frequently leads to postmenopausal and senile osteoporosis. Note typical atrophic changes characteristic of postmenopausal osteoporosis (fig. 1), in contrast to normal bone matrix (fig. 2).

Not generally realized is that some degree of osteoporosis is almost "physiologic" after the menopause, and that this bone disorder is present clinically in about 10 per cent of all women over 50 years of age.*

With combined estrogen-androgen therapy, pain in the spine and other bones is markedly relieved in a matter of weeks or months. The prognosis for bone recalcification, following extended periods of treatment, is good.*

Estrogen and androgen as combined in "Premarin" with Methyltestosterone provide a dual approach for maximum efficiency in treating osteoporosis. A brochure outlining full details of therapy is available on request.

*Reifenstein, E. C., Jr., in Harrison, T. R.: Principles of Internal Medicine, Philadelphia, The Blakiston Company, 1950, p. 655.

"Premarin" with Methyltestosterone is supplied in two potencies: the *yellow* tablet (No. 879) contains 1.25 mg. of conjugated estrogens equine and 10 mg. of methyltestosterone; the *red* tablet (No. 878) contains 0.625 mg. and 5 mg. respectively. Both potencies are available in bottles of 100 and 1,000 tablets.

"PREMARIN" with METHYLTESTOSTERONE
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Ayerst Laboratories • New York, N. Y., Montreal, Canada

To restore the "know-how"



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capsule contains
0.30 Gm. of
glutamic acid
hydrochloride
with 0.25 Gm.
of mephenesin.

relaxation

for anxiety-tension patients

Mephate® is a preferred skeletal-muscle relaxant, because its glutamic acid hydrochloride component enhances the systemic action of the mephenesin, thus providing:

- effective relaxation on lower mephenesin dosage*
- therapeutic response in many patients previously unresponsive to mephenesin alone.*

A. H. ROBINS CO., INC., Richmond 20, Virginia
Ethical Pharmaceuticals of Merit since 1878

Mephate®

the improved relaxant



*Hermann, I. E. and
Smith, R. J.: *Journal*
Lancet 71 273, 1951.

ences to material in books in a similar manner.

One of my colleagues tells me that his aide clips and classifies articles, then passes them on to him for reading. I don't feel that my assistant is experienced enough for any such responsibility. And, besides, I like to index while reading. I find that it increases my efficiency because it keeps me from going off on tangents.

After my secretary has clipped a copy of a periodical, she throws it away—except for the Journal A.M.A. (which we keep for two years) and the specialty journals (which we keep for five). Though I seldom look at them again, I like to save them just in case.

My file now contains some fifty folders. In choosing subject headings, I follow the index of the Journal A.M.A. pretty closely—though I supplement this list with some headings from specialty journal indexes.

I began with this system and I don't plan to change it. But if I were to start over again, I'd probably base my subject headings on those in the A.M.A.'s "Quarterly Cumulative Index Medicus: Subject Headings and Cross References."

No matter what the list of headings, the important thing, I've learned, is to stick to my choice. Our file would be utterly disrupted if, for example, I classified one article as "CARDITIS" and another on

for all
treatable anemias

TRINSICON

(Hematonic Concentrate with Intrinsic Factor, Lilly)

Lilly

new, improved formula
50% more potent
in antiserious
anemia factor

20 cc. PROVIDE THERAPEUTIC QUANTITIES OF ALL KNOWN ANTIANEMIA FACTORS

The Infra-red Effect

**Improves circulation,
relieves pain**
in peripheral vascular disorders.

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Vasodilator, Metabolic Stimulant Tablets

Each VASTRAN tablet provides a high dosage of oxidative coenzymes of the B-complex—including nicotinic acid (50 mg.), for safe, rapid vasodilatation in peripheral vascular disorders. Patients experience a warm, tingling flush of the face, neck and arms, much like the sensation they feel after exposure to an infra-red lamp. This "Infra-red effect" is positive evidence of VASTRAN's vasodilator action.

HOW VASTRAN RELIEVES PAIN

- 1st VASTRAN's effective vasodilating action rapidly oxygenates tissues and relieves ischemia, a major source of pain.
- 2nd VASTRAN's anti-ischemic formula provides important coenzymes to metabolize accumulations of toxic substrates resulting from inadequate oxidation.

• **Indications**—Peripheral vascular disorders, intermittent claudication, Meniere's syndrome, chronic arthritis, bursitis . . . as well as tension headache, migraine and neuralgia.

• **Dosage**—1 tablet t.i.d., preferably on an empty stomach. Note if desired, the "Infra-red effect" can be avoided simply by prescribing VASTRAN at mealtimes.

• **Formula**—Each VASTRAN tablet supplies:

Nicotinic acid (Niacin)	50 mg.
Ascorbic acid (Vitamin C)	100 mg.
Riboflavin (Vitamin B ₂)	5 mg.
Thiamine mononitrate (Vitamin B ₁)	10 mg.
Pyridoxine HCl (Vitamin B ₆)	1 mg.
Vitamin B ₁₂ (from fermentation extractives)	2 mcg.

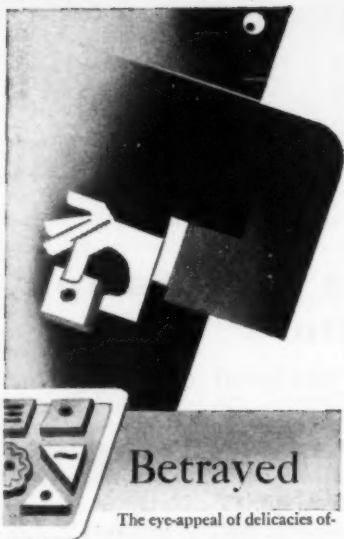
• **Supplied**—bottles of 100 and 500 scored tablets.

Samples and clinical literature on request

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The eye-appeal of delicacies often creates an irresistible urge to "sample" beyond one's better judgment, with acid indigestion a possible result. Patients tempted this way will find grateful relief from stomach upset, when due to excess acidity, by trying BiSoDol—tablets or powder. BiSoDol acts fast, gives prolonged relief, protects irritated stomach membranes. You can recommend pleasant-tasting, dependable BiSoDol with complete confidence. Samples on request.

fast / acting

BiSoDol

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180

MEDICAL READING

the same subject as "HEART DISEASE." Think of the trouble a new secretary would have with any such inconsistent system!

For much the same reasons, I keep all subject headings as specific and as narrow in scope as possible. I index an article on angina pectoris under "ANGINA PECTORIS," for instance, not under the broad heading, "HEART DISEASE." Thus, the folders don't get too bulky; and items are easier to find.

I've also learned to steer clear of catch-all headings like "MISCELLANEOUS." They're a temptation, I admit. But they can put a crimp in the most efficient filing system.

In cases where two terms are used interchangeably, such as Adrenalin and epinephrine, I use only one folder. But, as an aid to the secretary—or to anyone else who may not be familiar with the file—I provide the necessary cross reference. Under "ADRENALIN," for example, there's a guide card that says, "See EPINEPHRINE."

And the file also gives quick reference to various allied subjects. For instance, the "ARTERIOSCLEROSIS" folder carries the notation, "See also HYPERTENSION."

If you decide to use an indexing system like mine, you'll be able to locate useful information in a matter of minutes. But remember, after you set it up, to stick to it.

And remember this, too: Better a modest index than one that's so ambitious you can't keep it going. END

pain

has two aspects

physical

psychic

Daprisal*

relieves both aspects of pain

physical—because it provides the combined analgesic effect of acetylsalicylic acid and phenacetin, potentiated by amobarbital.

psychic—because it provides the mood-ameliorating effect of Dexamyl* (Dexedrine† and amobarbital).

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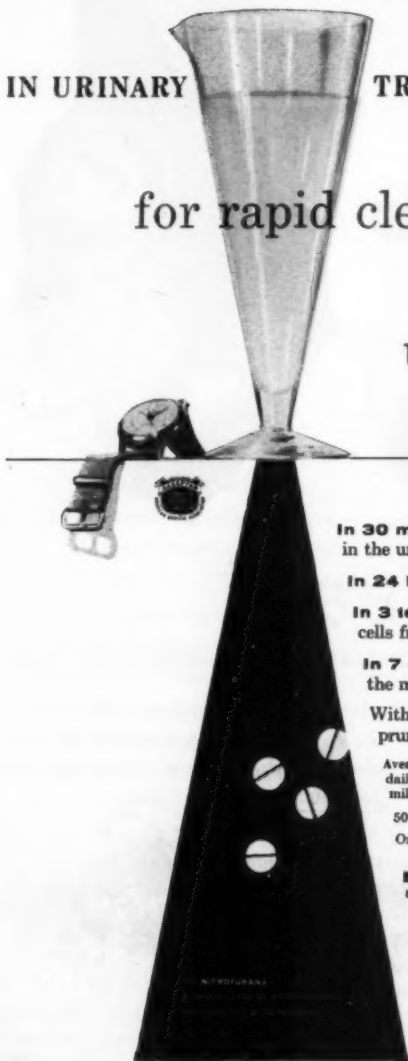
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In 30 minutes: antibacterial concentrations in the urine

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With Furadantin there is no proctitis, pruritus ani, or crystalluria.

Average adult dosage: Four 100 mg. tablets daily, taken with meals and with food or milk before retiring.

50 and 100 mg. tablets.

Oral Suspension, 5 mg. per cc.

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Medical Social Service Gets Biggest Test

Now that doctors in the nation's largest city have hired a full-time consultant, some are wondering how they ever got along without her

By Peter Jaeger

● Six years ago, when the trail-blazing doctors of Oakland, Calif., hired a full-time social service consultant for their medical society, some observers thought the innovation a dubious one. But it proved so successful that physicians in other areas soon followed suit. Now the idea is being given its largest-scale tryout yet—in the nation's biggest city.

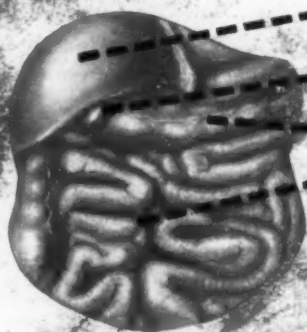
The social service department of the New York County medical society began to function last spring. Its aim, according to Robert D. Potter, the society's executive secretary: "to render a more personal service to the doctor by expanding his opportunity to be an adviser and counselor to his patients." And New York's physicians already seem enthusiastic about it.

Directed by Miss Shirley Decker, the department performs a variety of services. For one thing, it helps local doctors to set fair fees in certain cases by ferreting out the facts about the patient's economic status. For another, it helps settle doctor-patient disputes before they reach the grievance stage. Finally—and to a far greater extent than similar services elsewhere—it acts as a liaison between local medical men and the more than 1,000 community

VERACON

THE BILE SALTS LAXATIVE

Illustration by
J. Gilmore, Ph.D.,
based on
figure study
by Rubens



DATE

TIV. works throughout hepato-intestinal system

FORMULA: Each tablet contains Bile Salts 1.07 gr., Ext. Cascara Sag. 1.00 gr., Phenolphthalein 0.50 gr., Oleoresin Capsicum 0.05 min.

- 1 LIVER**—Veracolate stimulates liver action, increases flow of bile—nature's own laxative.
- 2 GALL BLADDER**—flushed and thoroughly emptied by free-flowing bile.
- 3 SMALL INTESTINE**—Veracolate improves fat digestion. Its bile salts prevent flatulence, "biliousness" and distress after eating. Other components improve intestinal tone and peristalsis.
- 4 COLON**—Veracolate has a mild yet dependable laxative effect. Dosage (1 tablet t.i.d. or 2 tablets at bedtime) can be readily adjusted to suit each patient.



Box of 12 sample packets, each containing 6 tablets, available on request. Write the Medical Director, Standard Laboratories, 113 West 18th St., New York 11, N. Y.



PROTAMIDE® for NEURITIS

...types resistant to other therapy—where nerve root inflammation is not caused by mechanical pressure¹

COMPLETE RELIEF OF PAIN

in 80.7% of patients...
52.9% in 5 days¹



PROTAMIDE® for HERPES ZOSTER

...even cases unresponsive to a wide variety of other medications²

GOOD TO EXCELLENT RESULTS

in 82.7% of patients in two studies...
70.4% with 5 injections or less^{2,3}

USE PROTAMIDE® FIRST

...as early as possible in
the course of the illness

in Neuritis—COMPLETE RECOVERY IN 100% of patients when Protamide therapy was started not later than the fourth day of illness... 80.3% recovering after five days of therapy.¹

in Herpes Zoster—GOOD EXCELLENT RESULTS IN 82.7% of patients (80% with 5 injections or less) when Protamide therapy was started during the first week of illness.^{2,3}

PROTAMIDE® IS SAFE

with "no untoward reactions or
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PROTAMIDE is a sterile colloidal solution of proteolytic denatured proteolytic enzyme obtained from the glandular tissue of fresh hog stomach. It is supplied in boxes of ten 1.3 cc. ampuls and the usual dosage is 1 ampul daily by intramuscular injection. Available through your regular source of supply.

REFERENCES:

1. Smith, R. T.: New York Med. J. 16, 1932. 2. Campbell, F. C. & Cantarero, O.: New York St. J. Med. 52:706, 1952. 3. Marsh, W. C.: U.S. Armed Forces M. J. 1:1048, 1950.

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BIOLOGICALS • PHARMACEUTICALS

health and welfare organizations.

A typical problem dumped in Miss Decker's lap was this one, from a Manhattan G.P.: Where could a patient who badly needed psychiatric care get such treatment inexpensively?

"She's a 30-year-old woman whom I recently referred to a hospital consultation service for psychiatric examination," he explained. "The diagnosis was mild schizophrenia. The hospital can't take her on, and yet she needs therapy immediately. Can you help her?"

The woman's condition was such that she wouldn't allow her husband to leave her, not even to go to work. "So," says Miss Decker, "the most this couple could afford to pay for treatment was between \$5 and \$7.50 a week; and they could afford *that* much only if the husband was working."

Clinic Accepts Her

Shirley Decker queried several clinics before she found one with available facilities. Though this institution already had a patient overload, the staff agreed to take on the additional patient at a \$7.50 weekly fee. Miss Decker also helped the woman arrange to delay payment until her husband had again begun to work. And within a few weeks, the patient's condition had improved to a point where the husband could return to his job.

In another case, a physician asked Miss Decker to try to help him find

a nursing home for a 65-year-old man. "The poor old fellow needs continued medical treatment," said the doctor, "so we've got to find an inexpensive home within easy reach of the city."

It took Miss Decker only a short time to locate just the place. And the doctor was, in a way, more grateful than the patient. "Without the help of your department," he said later, "I'd have been on the phone for hours, calling every nursing home I know of—and, probably, without success."

Unusual Request

Not all problems are so easily solved. Some of the department's toughest assignments come from laymen, who are learning in increasing numbers about the medical society's newest service. Not long ago, an expectant mother telephoned the office. "Please," she asked Miss Decker, "where can I get a saliva test?"

Under gentle prodding, she explained what she meant: She had read somewhere about a saliva test to predetermine the sex of an unborn child; and now she wanted to take one.

Undaunted even by such a request, Miss Decker got to work. One agency asked her if the saliva test were for a dog; others refused to take her seriously; but she persisted and finally found a maternity center that knew what she was talking about. "Probably the woman just

FOOD-PROOF

your
fat
patients



Obocell®

DOUBLES THE POWER TO RESIST FOOD

Each Obocell tablet contains:

d-Amphetamine Phosphate (dibasic)... 5 mg.
Nicel* 150 mg.

*Irwin-Neisler's Brand of High Viscosity
Methylcellulose.

Bottles of 100, 500 and 1000.

IRWIN, NEISLER & CO.
DECATUR, ILLINOIS

MEDICAL SOCIAL SERVICE

wanted to know whether she should knit pink or blue booties," Miss Decker says. "But we did our job anyhow."

Economics, Too

Though it stresses social service the department also works closely with the society's bureau of medical economics and with its grievance committee. Here are two examples of Miss Decker's activities in these areas:

In one case, a hospitalized influenza patient had been billed \$105 for her doctor's medical services. The woman protested the bill and brought her complaint to the grievance committee. On the basis of some ten visits from the doctor, plus several penicillin shots, she felt that his total fee should not have exceeded \$75. On the same basis, the physician himself naturally—and quite firmly—disagreed.

Strapped for Money

The committee asked Miss Decker to investigate. So she called on the woman and discovered that she and her husband lived in a modest apartment in a run-down section of the city. The husband, a grocery clerk, had to support his aged mother. And, it turned out, they were strapped for money: Because the husband suffered from hay fever, there was a continuous expense of \$5 a week for allergy shots; and, in addition, they owed a dental bill of \$100.

[MORE→]

RVIC

he should
s," Mr.
our job

service
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grievance
examples
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MORE→

Eskay's Neuro Phosphates*

a palatable and effective tonic

Eskay's Theranates*

the formula of "Neuro Phosphates" plus Vitamin B₁

To stimulate appetite and restore general tone

Smith, Kline & French Laboratories, Philadelphia ★T. M. Reg. U. S. Pat. Off.



2 tsp. t.i.d.

XUM

SQUIBB ANNOUNCES TWO IMPORTANT

THE FIRST
antifungal antibiotic
MYCOSTATIN

SQUIBB NYSTATIN

Highly effective for prevention and treatment of intestinal moniliasis

The intestinal flora of patients treated with oral antibiotics, particularly the broad spectrum preparations, undergoes profound changes. In many cases there is a strong overgrowth of *Candida* (monilia), and the extent of overgrowth seems to be proportional to the amount of the antibiotic taken. This phenomenon does not necessarily lead to clinical moniliasis, but a considerable number of patients with an overgrowth of *Candida* have intestinal symptoms, including diarrhea, ulceration, anal fissure, and persistent pruritus.

When such effects are due to *Candida*, they can be prevented by Mycostatin. Established monilial infection of the gastrointestinal tract can be cleared up by Mycostatin in 24 to 48 hours.

'Mycostatin' is a Squibb trademark

Dose: 500,000 units t.i.d.; to be doubled if intestinal fungi are not suppressed. Mycostatin is well tolerated by nearly all patients, and is compatible with the commonly used antibiotics.

*500,000 unit tablets
Bottles of 12 and 100*

XUM

BROAD SPECTRUM
ANTIBIOTIC OF CHOICE

STECLIN

HYDROCHLORIDE

Squibb Tetracycline Hydrochloride

Steclin is the newest broad spectrum antibiotic.

- Fewer side effects, better tolerated than oxytetracycline or chlortetracycline.
- Greater stability in blood serum.
- Efficient distribution to tissues and body fluids.
- Fully effective blood levels.

50 and 100 mg.
capsules
Bottles of 25 and
100
250 mg. capsules
Bottles of 16 and
100

SQUIBB

The range of clinical usefulness of Steclin is similar to that of oxytetracycline and chlortetracycline. It is often superior to its analogs because therapeutic blood levels are achieved with fewer gastrointestinal side effects.

As with all broad spectrum antibiotics, overgrowth with nonsusceptible organisms, particularly monilia, may occur.

"Steclin" is a Squibb trademark

MEDICAL SOCIAL SERVICE

Miss Decker reported these facts to the committee. As a result, the doctors ruled unanimously that, while the original fee had been reasonable, this was a hardship case—and that, therefore, a reduction in fee was advisable. The woman's physician readily agreed to this decision, and the bill was settled for \$75.

M.D. Cancels Debt

In another case, a doctor referred a year-old unpaid bill for \$175 to the society's bureau of medical economics. When Miss Decker was asked to investigate, she found that the original fee for surgery had been \$350; that \$175 had been paid off during the year; and that during that

time the patient had not only been unable to work, but had been in and out of hospitals for treatment of arthritis.

The patient frankly acknowledged that he didn't think the bill was excessive. But he explained that current circumstances made prompt payment impossible. After this information had been relayed to the physician, the entire debt was canceled outright and the case considered closed.

Has the New York experiment proved a success, then? The society still takes a "wait and see" attitude. The consensus seems to be that any such program needs a full year to prove—or fail to prove—its worth.

KRM

reflection of
RELIABILITY...

Koromex

ACTIVE INGREDIENTS: ZINC OXIDE, BENZOYL PEROXIDE, TITANIUM DIOXIDE, CALCIUM HYDROXIDE, AND OTHER MEDICINALS.
TAKEN TOGETHER, THEY MAKE KOROMEX THE MOST EFFECTIVE SKIN CARE PREPARATION.

Send for this unusual free booklet



Pragmatar* highly effective in an unusually wide range of common skin disorders

'Pragmatar' offers these outstanding advantages:

- A superior tar-sulfur-salicylic acid ointment incorporating a unique oil-in-water emulsion base.
- Wide margin of safety which enhances Pragmatar's usefulness in patients of all ages.
- Pleasant to use; non-staining; not unpleasantly greasy.



Seborrheic dermatitis

Characteristic frontal lesions of seborrheic dermatitis. Lesions may also appear on the temples, behind the ears and in the external auditory canal.

This patient had suffered chronic seborrheic dermatitis for 6 years. Treatment with 'Pragmatar' brought this marked improvement in the lesions in just 28 days.



Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

'Quotane'—potent topical anesthesia without undue risk of sensitization in PRURITUS ANI



Pruritus ani lesion,
showing inflammation caused
by scratching. Quotane's anesthetic
effect controls the urge to scratch.

Quotane* Hydrochloride Ointment Also available: 'Quotane' Lotion

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S., Pat. Off. for dimethisoquin hydrochloride, S.K.F.
(1-[β -dimethylaminoethoxy]-3-n-butylisoquinoline hydrochloride)

Medicine Beckons

The Feature Writers

With nearly everyone else writing about the latest in medicine, maybe the sports, society, and gossip columnists will soon get in the act. If they do, here's what you can anticipate

By Justin Dorgeloh, M.D.

● Doctors today can't complain that medicine's light is buried under a bushel. The layman can hardly open a newspaper without discovering at least one new cure for *something*. He follows the exploits of medical men in the Reader's Digest, Collier's, and the Saturday Evening Post. He masters the fundamentals of medical lore through Time or Newsweek (sometimes even putting himself one up on the too-busy doctor).

Yet the most telling blows for medicine are probably struck in novels, the funny papers, the cinema, and on radio and television. (Radio, for instance, has plugged medicine from the start—though, as has been pointed out, the detergent-drama heroes *do* seem overly susceptible to curable brain tumor and to the temporary loss of the use of both legs.)

Actually, no medical subject served with a garnish of scenario is beyond the lay appetite. So it's strange that those responsible for delivering medicine to the people have neglected certain spheres of literature that would increase its over-all coverage. For instance:

How about the layman who reads only the sports sec-

THE FEATURE WRITERS

tion of his newspaper? Or just the society page? Or nothing but the sagas of the gossip columnists? Some readers just won't devour anything that's not composed in the style to which they've become accustomed. In these circumstances, I maintain, it's medicine's clear duty to reach this untapped audience.

Let's say we have a thrilling account of a brand-new surgical operation to unfold to an expectant public. We know that the public today expects something sensational (what with artificial kidneys, redesigned hearts, and nylon aortas). So we propose replacing fistulous colons with puncture-proof inner tubes salvaged from imported sports cars.

To our maiden operation we in-

vite an assortment of top-flight writers. What will they report to their readers?

First, note the product of standard medical journalism as already found in the news magazines and in the general periodicals. Here, for instance, is how our operation is likely to be introduced in Time's medical section:

Guts and Inner Tubes

Doctors throughout the nation stood helplessly by as countless patients succumbed to the ravages of ulcerative colitis. Not so Chicago's Charon Hospital's trailblazing surgeons, who decided to try out a radical new treatment. Reason: Ulcerative colitis is no joke.

One muggy morning last week, lantern-jawed, beetle-browed Dr.

IN ANXIETY AND TENSION

**Sedation
without
hypnosis**

IN HYPERTENSION

**a safer
tranquillizer and
antihypertensive**

Felix Flotsam took scalpel in hand, nodded to hawk-nosed, bug-eyed Dr. Hans Jetsam. Thus began the first operation to replace worn-out colons with rubber inner tubes . . .

Or in the Reader's Digest:

The Most Unforgettable Colon I've Met

One memorable day last month I was summoned to witness an exciting new surgical operation, a fulfillment of mankind's oldest dream: the attainment of an artificial colon.

A hush descended on the operating room as two brilliant young scientists entered in cap and mask. It was they who had conceived the bold surgery I was about to behold. Their names? Dr. Felix Flotsam and Dr. Hans Jetsam.

Amid the ensuing hum of prepara-

tory activity my mind turned back to the dramatic incidents which inexorably led to this unforgettable scene:

One summer day in 1892, a school-boy named Felix Flotsam was busily repairing a punctured tire from his bicycle. Felix, ever a thoughtful boy, said to himself: "There **must** be some use for these worn-out inner tubes" . . .

Now to try out the *new* vehicles for carrying our message to the public. Take first the radio broadcast:

Good afternoon, sports fans. This is Lefty Bunt bringing you a play-by-play report on the artificial colon operation at Charon Hospital.

The Charon battery today is Flotsam and Jetsam, at present warming up with towel-clips . . . Here

FOR MAINTENANCE THERAPY

Rx as little as
0.1 mg. per day

Serpasil

a pure crystalline alkaloid of rauwolfia root first
identified, purified and introduced by CIBA

C I B A LIMITED, S. A.

THE FEATURE WRITERS

come the umpires with their microscopes . . . Dr. Mayhem throws away one of his hemostats and steps up to the operating table.

Mayhem is currently batting .492 with the Tissue Committee. Last month was rugged for Mayhem—a flock of normal appendices dropped him 200 percentage points. I understand two of those cases are still under protest, and may go all the way to the Commissioner . . .

Wait! Mayhem has missed three bleeders with his hemostat . . . A pinch surgeon is going in . . .

Or suppose the New Yorker magazine sent its man Stanley to report the operation:

Glorious day outdoors Tuesday. I was indoors, at Charon Hospital. Big hubbub about an operation to

replace a colon with an inner tube. Asked student nurse if it was a gag. She said no, operation to start in half an hour. Watched surgeon sitting in a circle, sharpening knives and exchanging anecdotes. Something in the air smelled like ether; asked nurse what it was. Ether. Service station man entered with inner tube. Big patch on tube . . .

The society editor of the local newspaper could well carry our message to influential quarters something like this:

On Tuesday last, Dr. Felix Flotsam of the Ebbside Yachting Club and Dr. Hans Jetsam of the Grassy Green Country Club were hosts to a notable group of doctors at Charon Hospital. Dr. Flotsam was attired in white gown, green mask, and

NEW...SUSPENSION

Remanden.

PENICILLIN WITH BENEMID®

extends the scope of penicillin therapy

SUPPLEMENTS AND AUGMENTS INITIAL INTRAMUSCULAR PENICILLIN

To intensify penicillin therapy and maintain optimum penicillin concentration, follow an initial "loading" dose of 300,000 units of intramuscular penicillin with 2 Tablets of REMANDEN or 2 teaspoonfuls of Suspension of REMANDEN every 6

or 8 hours. For children, the follow-up dosage is based on 40 mg. of 'Benemid' per Kg. of body weight per day in divided doses, every 6-8 hours.



Philadelphia 1, Pa.

DIVISION OF MERCK & CO., INC.

MEDICAL ECONOMICS • DECEMBER 1954

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mg. of
eight per
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, Inc.



ELECTRON PHOTOMICROGRAPH

Klebsiella pneumoniae 29,000 X

Klebsiella pneumoniae (Friedländer's bacillus) is a Gram-negative
capsulated organism commonly involved in
various pathologic conditions of the nose and accessory sinuses,
in addition to bronchopneumonia and bronchiectasis.

It is another of the more than 30 organisms susceptible to

PANMYCIN *

100 mg. and 250 mg. capsules

*TRADEMARK, REG. U.S. PAT. OFF.

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ILOTYCIN

(ERYTHROMYCIN, LILLY)

FIRST

...because
'Ilotycin' is
notably
safe

No allergic reactions to 'Ilotycin' have been reported in the literature. Staphylococcus enteritis, anorectal complications, moniliasis, and avitaminosis have not been encountered.

Lilly

Available in tablets,
suspension,
and I.V. ampoules.

THE FEATURE WRITERS

chartreuse cap. Dr. Jetsam wore a green gown with contrasting white cap and mask, and . . .

The man-about-town columnist, Herbert Busybody, in his daily "Laff, Town, Laff" should prove an effective carrier too:

Science 'n stuff. Last Tuesday yours truly got hisself an invite to Charon Hosp. to see a new loperation (ha!). Seems the local medico society needed somebody wit' oodles of readers (that's yours truly!) to give the op. a good send-off. So here goes on wot's new wit' doctors.

* * *

Fare enuf. On Tues. AY-EM I hopped a Tax-ee to Charon Hoospital. The cabbie, a real character (they're all characters), told about a recent fare he'd had. Seems a boo-ful blonde in mink who flagged his cab had dress, pink bra, and panties over her arm. When the doll got out at her home-sweet-home and reached for the do-re-mi, the mink slipped off her shapely shoulders and dropped to the ground. Now lissen, chillun, for the switcheroo: The chick was stark fully clothed . . .

* * *

L'operation. Got gowned and masked in a room filled with Dr.'s and boo-ful F. Nightingales. Doc Felix Flotsam was emceeing the surgery. Felix's wife Sandra is a bundle of booty, the erstwhile property of playboy Jimmie Balast. 'Twas in 1952 that Sandra and Jimmie finally parted, no hard feelings, in Reno. Jimmie's pals say he's still toting the torch for Sandra . . . One of the docs at the op'rating table was wearing a long face. Seems he's in the minestrone with the Tissue Committee. In case the news busts out

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THE FEATURE WRITERS

all over, don't forget: another SKOOP for Busybody! . . . Didja ever wonder how the em-dees can work, wit' all them gor-jus nurses buzzin' roun'? . . . Incident'ly, one of the gals in white was Miss Southside District of 1949. First name's Sally, and the last name wild horses couldn't drag from yours truly. The initial is M. If ya r'member. Sally got hitched back in '49 and the guy turned out to be a heel. Well, Sally's got a new hubbie now, and she's bravely trying to forget the past. Good luck, Sally! . . .

* * *

Add Lib. Doc Tom Humerus was amongst those present-and-acc'td-for at the op'ration. He's a real wit, and that's no half-way compliment (get it?). F'rinstance, he was helping close up Nick Toper's nite spot last week with that gor-jus Margot Vermicularis (yep, she's back from Reno a'ready—how six weeks flies!) when Nick asks him for pr'fessional advice. How can he (Nick) give up the weed (m'eaning cig'rettes)? "There's nothin' to it," says Dr. Tom. "I quit smokin' at least once a week."

* * *


OKEH, chillun, that's enuf fer now. Tomorrow yrs. truly'll be back to reg'lar reportin' of the dissa and datta of our Fabulous Town. Glad ta have bin of service, Docs!

Perhaps these examples of varie-gated medical reporting will stimu-late others to explore more fully this exciting field of literary exposi-tion. If so, I can foresee the day when medical chitchat from the col-umnists and commentators will be as much a part of life as the common housefly.

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✓replace...

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vitamin B₁₂

injections



Each Biopar tablet contains:

Crystalline Vitamin B₁₂ U.S.P. 6 mcg.

Intrinsic Factor 30 mg.

Bottles of 30 tablets



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Salmonella paratyphi B 23,000 X

Salmonella paratyphi B (*Salmonella schottmuelleri*) is a

Gram-negative organism which causes

food poisoning • chronic enteritis • septicemia.

It is another of the more than 30 organisms susceptible to

PANMYCIN^{*}

100 mg. and 250 mg. capsules

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XUM

Should Blood Banks Make Money?

By Bill Davidson

"BLOOD WITHOUT CHARGE" is a concept that has been widely publicized by advocates of the Red Cross blood collection program. As a result, many people have come to distrust agencies that charge patients for blood—even when the fee covers only the legitimate costs of collecting, processing, and administering it.

The following article* appeared in the November 12 issue of Collier's (the same magazine that last year published "Why Some Doctors Should Be in JAIL"). It charges that the country's blood supply is controlled "partly by idealists, partly by human leeches."

Is the author suggesting that doctors who oppose the Red Cross blood program are leeches? Many a reader will get that impression, and many a physician will resent the slur.

It hardly seems necessary to point out that MEDICAL ECONOMICS disagrees with much of what the author implies. But since the issue he raises has such significance for doctors, we are reprinting his article in its entirety. We'll be interested to hear what you think of it.

● Last May, three women living in different parts of the country became desperately ill. They began to hemorrhage internally, and were rushed to hospitals, where emergency blood transfusions were necessary to save their lives. All three recovered, but there were revealing discrepancies in the events which followed.

The first woman lived in Kankakee, Ill., and the blood which saved her came from the American Red Cross Regional Blood Center in Peoria. She paid nothing for the four pints of blood she received.

The second woman lived in Houston, Tex. She received six pints of blood from a private blood bank operated under the auspices of the local medical society. After her hemorrhaging stopped, her family was told:

*Copyrighted, 1954, by the Crowell-Collier Publishing Company.

IN ANGINA PECTORIS

*A Closer Approach to
Definitive Therapy*



- Reduces nitroglycerin needs
- Reduces severity of attacks
- Reduces incidence of attacks
- Increases exercise tolerance
- Reduces tachycardia
- Reduces anxiety, allays apprehension
- Lowers blood pressure in hypertensives
- Does not lower blood pressure in normotensives
- Produces objective improvement demonstrable by EKG.

Descriptive brochure on request.

PENTOXYLON, the newest therapy in angina pectoris and status anginosus, combines the tranquilizing and bradycrotic effects of Rauwiloid® and the long-acting coronary vasodilating effect of pentaerythritol tetranitrate (PETN).

The rationale of this new combination is based in part upon the well-known observation that the frequency and severity of anginal attacks are augmented by fear and apprehension. The Rauwiloid effect in PENTOXYLON slows the rapid pulse which accompanies apprehension and pain. The slower heart rate, with its lengthened diastole, permits better coronary filling, more adequate ventricular filling, and wider stroke volume. Thus the work demand on the myocardium is diminished while PETN exerts its prolonged coronary dilating effect. PENTOXYLON offers therapy in angina without xanthines, without stimulation of cardiac rate or work.

Development of full effectiveness of PENTOXYLON requires about two weeks of therapy, though benefits have been observed after 24 hours. Continuing therapy over a period of time with PENTOXYLON—in the usual dosage of 1 tablet q.i.d.—reduces or abolishes nitroglycerin requirements.

PENTOXYLON™

Each tablet contains pentaerythritol tetranitrate (PETN) 10 mg. and Rauwiloid® 1 mg.

Another **Riker** *Original*

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"You now have to provide donors to replace *twelve* pints of blood—or we will have to charge you \$20 a pint for the six pints used, or \$120."

The third woman was taken to a hospital in New York City, where she was given four pints of blood. Though the hospital had bought two pints of blood from a private blood bank at \$12 apiece and had received the other two pints free from the Red Cross, the woman was charged \$84 for the purchased blood and \$44 for the free Red Cross blood. She also had to pay \$102 for "laboratory service"—which, in her case, was simple blood typing, a routine procedure which takes no more than a few minutes—bringing her total bill to \$230.

Do these stories make you think that the blood supplies of America are controlled partly by idealists, partly by human leeches? To a shocking degree, that's true.

A Plan to End Chaos

It would seem that nothing could be less complicated than the elementary humanitarian procedure of providing human blood to save human lives—but there's no field of medicine where there is so much confusion today. Besides the almost unbelievable disparity in prices, the national blood situation involves greed, politics, danger to health, trade in human suffering. It also involves individual sacrifice and nobility of purpose.

There are good blood banks and

bad blood banks. In some areas, there is strict medical control; in others, *anybody* can go into the blood business, much as anybody can open a delicatessen. There are plans that would continue the chaos, and one over-all plan that offers great hope of ending it.

The chaotic blood situation has led to unprecedented bitterness in medical circles, with ugly charges and countercharges disrupting normally serene medical conclaves. Dr. Albert Wolf of Chicago's Michael Reese Hospital told me, "I have never heard such vitriol in my years of practice."

Typical was a meeting of the Harris County Medical Society in Houston, at which a local doctor addressed himself to Dr. David N. W. Grant, respected medical director of the American National Red Cross and former Surgeon General of the Air Force. The local doctor sputtered, "No dirty socialistic bureaucrat from Washington is going to come down here and tell us what to do." At this meeting, the local medical society voted to cancel its agreement to allow the Red Cross to establish a Regional Blood Center in Houston, maintaining that the Red Cross promotes socialism by adhering to a policy of giving blood without charge to all residents of an area.

A few days later, the conservative Houston Post pointed out with irony that the Red Cross board of governors included such rabid "socialists" as Union Pacific board chairman E.

improve
the RBC count
raise
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INTRIBEX Kapseals®

Because they provide essential factors for production and maturation of red blood cells and for hemoglobin regeneration, INTRIBEX Kapseals produce optimal hematopoietic response in your anemic patients.

each Kapseal contains:

Intrinsic Factor Concentrate containing
7.5 mcg. Vitamin B₁₂ ½ U.S.P. Oral Unit*

TO WHICH HAS BEEN ADDED THE FOLLOWING:

Ascorbic Acid	75 mg.
Folic Acid	1 mg.
Vitamin B ₆ , Crystalline	7.5 mcg.
Ferrous Sulfate, Exsiccated (5% gr.)	375 mg.
Liver-Stomach Concentrate	200 mg.

*Potency established prior to admixture.

Supplied in bottles of 100 and 500.

dosage In uncomplicated pernicious anemia or other types of megaloblastic anemia, 2 INTRIBEX Kapseals each morning or 1 INTRIBEX Kapseal morning and night. In hypochromic anemia or severe nutritional anemia, 3 or 4 INTRIBEX Kapseals daily.



Parke, Davis & Company

DETROIT, MICHIGAN

SHOULD BLOOD BANKS MAKE MONEY?

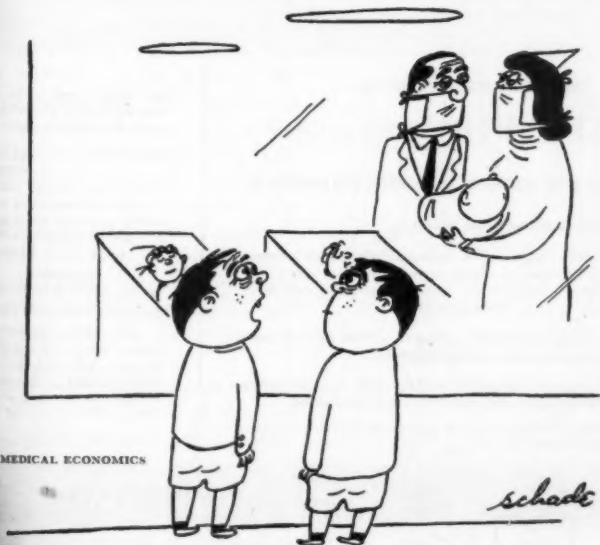
Roland Harriman and Sears, Roebuck vice-president Charles H. Kellstadt.

But there are even nastier charges than socialism, involving the unpleasant terms "profiteering in blood" and "trafficking in human misery." The Red Cross, of course, is a nonprofit organization, and so are most of the excellent, doctor-supervised institutions like Seattle's King County Central Blood Bank, the Irwin Memorial Blood Bank in San Francisco and the Junior League Blood Center in Milwaukee. Such groups obtain all or most of their blood from free voluntary do-

nations and they charge no more than the cost of collecting and processing it. "On the other hand," says Dr. Paul L. Wermer, secretary of the Committee on Blood of the American Medical Association, "there is no doubt that a few less scrupulous blood banks have been profiteering. This is deplored by all national organizations concerned with blood collection."

'Skid Row' Derelicts

Many of the profiteering charges involve so-called "skid row blood banks" which can be found in every major city. Bums come to these es-



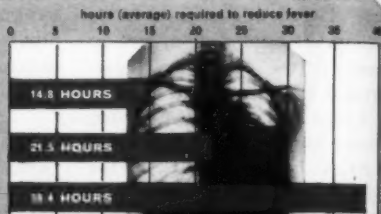
"How should I know his name? He can't talk yet."

combined action means faster patient recovery

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PARENTERAL PENICILLIN

SULFADIAZINE



Vollmer, Pomerance and Brandt observed that the administration of sulfonamide mixtures when combined with penicillin reduced fever in patients with pneumonia more rapidly than sulfadiazine or penicillin alone.*

the preferred quadri-sulfa mixture...

DELTAMIDE® w/penicillin

combines 4 of the most useful sulfonamides with penicillin for—

a wider antibacterial spectrum

the advantages of a sulfonamide combination:
faster therapeutic blood levels and better sustained;
higher solubility in the urine; greatly reduced renal
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the true potentiation of action that occurs with
the use of sulfonamide mixtures

the truly synergistic action that occurs when
sulfonamides and penicillin are combined

*Vollmer, H.; Pomerance, H. H., and Brandt, I. K.: New York State
J. Med. 50: 2293, 1950.

Each tablet or teaspoonful of the
pleasant-tasting chocolate-fla-
vored suspension contains:

DELTAMIDE	DELTAMIDE w/penicillin
0.167 Gm. sulfadiazine	0.167 Gm.
0.167 Gm. sulfamerazine	0.167 Gm.
0.056 Gm. sulfamethazine	0.056 Gm.
0.111 Gm. sulfacetamide	0.111 Gm.
— penicillin G	250,000 Units

Deltamide

Tablets: Bottles of 100 and 1000.

Suspension: Bottles of 4 and 16 oz.

Deltamide w/penicillin

Tablets: Bottles of 36 and 100.

Powder for Suspension: 60 cc. bot-
tles to provide 2 oz. of suspension
by the addition of 40 cc. of water.

also available **DELTAMIDE®**



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establishments and sell their blood as often as they can get away with it for \$5 or \$6 a pint. The blood bank, in turn, sells the blood to hospitals for \$15 or \$20 a pint. Many of the hospitals then charge the patient whatever they can collect—sometimes as much as \$100 a pint.

'The Sewer Phase'

Surprisingly often, the skid row blood banks are attached to reputable universities and hospitals. One, known as "The Butcher Shop" to the derelicts along New York's Bowery, is directed by a distinguished researcher. Although he is salaried and has never been accused personally of profiteering, a profit is certainly made by the institution which employs him.

Experts all over the country refer to this blood bank and others like it as "the sewer phase of our profession." In New York, derelicts have collapsed in the street and have been rushed to city hospitals in a critical state, after having made repeated donations of their blood—with the blood banks apparently unaware of (or indifferent to) the fact that the men were being bled almost to death.

The situation became so serious that in 1947 the Journal of the New York State medical society published an outspoken article which said: "These patients show certain common features. All were men, indigent, unemployed or unemployable. They were all residents of

either municipal lodghouses or cheap Bowery hotels. Eleven were chronic alcoholics. The small sums they received, five dollars a pint, were usually spent not on food, but on the purchase of more alcohol. Six patients had, as their primary diagnosis, lobar pneumonia, and one had the diagnosis of bronchopneumonia. There was one fatality in this group . . . He had given twelve transfusions in four months." (Reputable blood banks do not consider it safe for a person to give blood more often than once every three months.)

A number of safeguards have been set up since then, but skid row vagrants frequently manage to



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AT A POPULAR
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Old Gold
CIGARETTES
REGULAR SIZE

Old Gold
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Old Gold
CIGARETTES
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Regular Size...Filter Kings...King Size
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OLD GOLD FILTER KINGS

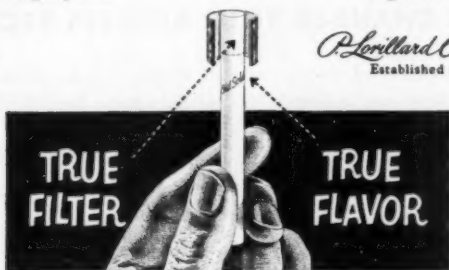
The One Filter Cigarette that Really Tastes like a Treat.

Here's the first famous name brand to give you a filter. And when you see the Old Gold name on the pack, you know you're getting a quality tobacco product.

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SHOULD BLOOD BANKS MAKE MONEY?

evade them. And since "The Butcher Shop" alone still supplies more than 100,000 pints a year for transfusions in hospitals as far away as Egypt and Turkey, the question naturally arises, "How safe is the blood of an alcoholic Bowery bum?" Most hematologists say that there is no danger—that if it can pass rigid tests set up by the National Institutes of Health, it is indistinguishable from the blood of a healthy, clean-living person.

Other doctors point out, however, that there are no known tests for malaria or jaundice—both of which can be transmitted to patients in blood transfusions. These doctors say that the only way to find out if a donor's blood may be infected with these diseases is to ask him if he ever had them.

"Now do you suppose a Bowery

bum is going to admit he had jaundice," they ask, "if it means he's going to lose five dollars?" The same situation may come up when friends or relatives offer to replace blood given to a patient by a private blood bank. There, too, a donor may lie if he knows a heavy financial penalty will be levied on the patient if the blood is not replaced on a two-pints-for-one or even a three-pints-for-one basis.

One Rochester, N.Y., physician told me, "If I ever have an accident in New York City, where there is both Red Cross and private blood, I hope they can move me back to Rochester before they give me a transfusion. In this area, we have only Red Cross blood, donated by volunteers. Unpaid volunteers don't lie about such serious matters as jaundice and malaria." [MORE→

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SHOULD BLOOD BANKS MAKE MONEY?

Organized medicine has avoided taking a stand on these as-yet-unresolved health questions, but there has been no mistaking its concern with the serious charges of profiteering. In June, 1952, the House of Delegates of the American Medical Association voted approval of the following principle:

What the A.M.A. Says

"Since blood is derived from human beings only, our aim should continue to be directed at having no profit from trafficking in whole blood itself; however, all services rendered cost something and are paid for by or on behalf of every recipient of such services. The service charge should cover all costs of the

operation, including depreciation and expansion reserves, but the realization of profit for the support of other institutional needs should be discouraged."

I asked Dr. Wermer, secretary of the A.M.A.'s Committee on Blood, to interpret this resolution for me, and he said, "It simply means that we feel you can't put a price on part of a human body—and that's what blood is. Therefore, buying and selling blood for profit, except when rare types can't be obtained in any other way, is unethical. As for service charges—covering the collection, storage and distribution of blood, equipment, maintenance and so on—costs vary from locality to locality, but \$7 to \$12 a pint seems fair in

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SHOULD BLOOD BANKS MAKE MONEY?

most parts of the country. If a blood bank charges much more than that, I'd say the money is being applied to something else."

Where the Money Goes

It is difficult to run down that "something else." Most private blood banks label themselves non-profit, but such a designation may mean only that the bank itself cannot show a profit at the end of the year. But it can earn hundreds of thousands of dollars and funnel the money off into other channels. Blood bank personnel can vote themselves handsome salaries, they can assign the money to questionable "research," pay the bills of affiliated organizations, give vague "grants"

to co-operating doctors—in short, do almost anything they want with the money.

At a recent meeting of the American Association of Blood Banks, Dr. Wermer was asked from the floor whether it was proper for blood banks to channel blood money into other functions, such as paying janitors' salaries in hospitals to which the banks are attached. He replied, "Even if the money is spent for worth-while purposes like research, it's unethical if the research has nothing to do with blood."

An A.M.A. investigating commission looked into such a situation in Miami, where the excellent, non-profit Dade County Blood Bank was associated with a profit-making



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SHOULD BLOOD BANKS MAKE MONEY?

blood-serum firm—most of whose profits went, in turn, to a third, non-profit, research outfit. The same doctors were on the board of directors of all three corporations. The commission found no evidence of wrongdoing, but said “widespread doubts and uncertainties” existed and recommended discontinuing the interlocking directorships and interchange of staff personnel.

Who's Doing It

Although still smarting under the commission's recommendation, one of the Miami doctors admitted that profiteering in blood was one of the biggest problems faced by the medical profession. “Over 4,000,000 pints of blood are used by civilians

in the United States every year,” he said. “That's a multimillion-dollar business.”

Like other industries, the blood bank field has attracted people of various backgrounds. The principal source of blood in Long Island, N.Y., for example, is Edward J. Madden, executive director of Inter-County Blood Banks, Inc. Madden—who has fought a successful battle to keep the Red Cross out of Long Island's Nassau County and to limit the distribution of Red Cross blood in Queens, on the ground that he can do the job better—had no previous blood bank experience before he got into the business in June, 1942. He was seen often at Florida race tracks, and at one time owned a

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stable of race horses (one of which he named Plasma).

Madden says he is in blood-banking strictly for humanitarian purposes and that he and his wife both work for the establishment without salaries. His income, he says, is derived from real-estate holdings in Florida. The blood bank is a non-profit corporation, supervised by a reputable hematologist, Dr. John M. Scannell, and it enjoys the support of three county medical societies.

His Books Are Open

Madden willingly offers his books for inspection. He showed them to me, and I noted that he suffered a loss of \$60,500 supplying blood last year to indigent patients at Mead-

owbrook Hospital in East Meadow, Long Island. I also noted that he has an over-all annual surplus of \$10,000 to \$30,000, which he says "goes to establishing other blood banks."

For each pint of blood administered, Madden demands a replacement of two pints of blood or a fee of \$35. His books indicate that seven persons in ten replace the blood; the rest pay cash. In 1953, the cash fees totaled nearly \$300,000. These figures serve as background for a curious incident in which Madden was involved in 1950.

On November 23d of that year, a Long Island Rail Road train crashed into the rear of another crowded train near the Jamaica station, and

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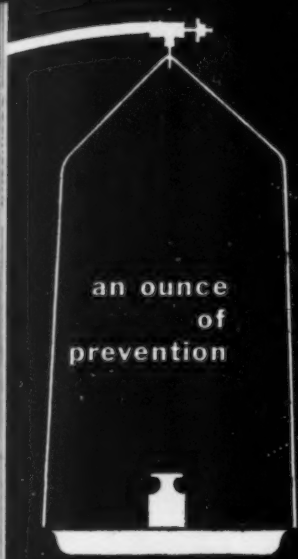
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1. Russek, H. I., et al.: J.A.M.A. 153:207 (Sept. 19) 1953. 2. Winsor, T., and Humphreys, P.: Angiology 3:1 (Feb.) 1952. 3. Plotz, M.: New York State J. Med. 52:2012 (Aug. 15) 1952.

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BLOOD BANKS

77 persons were killed. Dr. Marcus Kogel was then New York City's Commissioner of Hospitals and he rushed to the grim scene to supervise the rescue and treatment of 159 injured survivors.

Scene of Horror

As Dr. Kogel tells it, "The disaster operation was proceeding smoothly and we had plenty of blood from agencies set up to handle such emergencies, when suddenly a man named Edward J. Madden appeared. Without any authority from me, he grabbed the radio facilities and broadcast a call for volunteers to come in and donate blood. Soon the already chaotic area was clogged with thousands of well-meaning citizens answering his appeal. Some 3,000 donors turned up at Madden's blood bank in Jamaica and he collected 400 pints of blood from them. We used none of it."

Reporting on the same incident, The New York Times wrote editorially: "The brutal truth is that neither the radio appeal itself (which was not issued by the Red Cross) nor the generous rush of thousands of citizens to give their blood served any immediately useful purpose. On the contrary, traffic jams were created, sorely overtaxed hospitals were crowded with unnecessary donors and the atmosphere of semihysteria naturally generated by any major disaster could not help but be intensified . . . It can hardly be said that the public

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SHOULD BLOOD BANKS MAKE MONEY?

was victimized, for the blood given that night eventually was or will be used; but there seems to have been no necessity for the Inter-County Blood Bank to have added to the excitement and the confusion by issuing its radio appeal."

I asked Madden what happened to the 400 pints of free blood he collected. "We gave 100 pints," he said, "to hospitals caring for the train-wreck victims."

"And what about the other 300 pints?" I asked him.

"They went into our general blood pool," Madden explained; "but every donor got a credit of a half pint of blood in case he should ever need a transfusion."

Since only one person in 83 ever

requires a transfusion in the New York area, Madden that day gained about 296 pints of blood—worth more than \$10,000 at Madden's standard price of \$35 a pint.

Many doctors resent the intrusion of lay people into the blood bank business; but Madden has plenty of defenders in the Kings County, Queens County and Nassau County Medical Societies in New York. Why?

The Basic Issue

The answer goes back to a basic dispute about blood, stemming from two wholly divergent philosophies in the medical profession.

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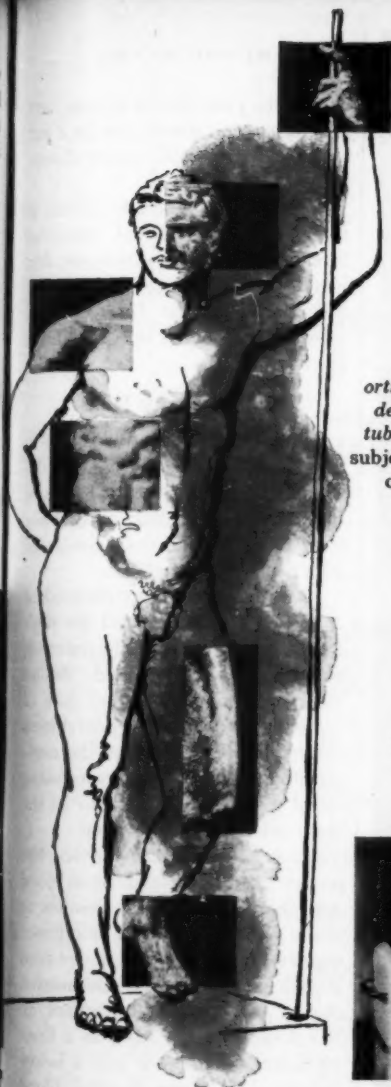
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BLOOD BANKS

agent, like penicillin or aspirin, and that the patient should pay for it just as he pays for other medical supplies.

A second group, led by doctors in the Red Cross and the American Medical Association, believes that blood is something special—a part of a human being, in Dr. Werner's words—and that no one can put a price on it.

In the Early Days

The roots of the controversy lie in the history of blood-banking—a development so new that in 1940 one big Chicago hospital gave fewer than 100 transfusions, compared with nearly 5,000 in 1953.

Blood banks were not established in the United States until the mid-1930s, when a method of preserving blood was first discovered. Before that, hospitals maintained lists of "walking blood banks"—paid donors whom they called in for the complicated procedure of transfusing blood directly from the veins of the donor to those of the patient.

Some hospitals early sensed the money-making possibilities in blood and charged distraught families as much as \$500 a pint for emergency transfusions. Other hospitals found it difficult to get blood and insisted that a patient's family replace all blood used—on as much as a four-pints-for-one ratio—or pay a heavy penalty fee. Some hospital blood banks found it easier to pay derelicts \$5 a pint than to hound relatives. A

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few institutions ran their blood banks on low-cost, humanitarian grounds. In general, a hospital's blood bank policy depended on which school of thought it favored—the "blood-is-just-another-drug" school, or the "blood-is-part-of-a-human-being" school.

Enter the Red Cross

But then came World War II, and almost overnight the hospitals lost their control of the situation. The armed forces needed millions of pints of blood to treat shock and wounds on the battlefield, and the handful of hospital blood banks just were not capable of delivering that volume. So at the request of the Army and the Navy, the American

Red Cross began to establish blood donor centers in 1941. Everyone knows the magnificent story of the wartime Red Cross blood centers.

More than 13,000,000 pints of blood were given freely by the American people to the Red Cross from 1941 to 1945 (and later, 6,000,000 more were donated through the Red Cross for our troops in Korea and for civilian defense against atomic attack).

But the war also opened a Pandora's box of trouble in the blood bank field. Here and there, so-called "community blood banks" sprang up, using the Red Cross technique of soliciting free contributions of blood for use in all local hospitals. Some even worked under

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* Smith, Jackson A.: Methods of treatment of Delirium Tremens, *Journal of the American Medical Association* 152:386, May, 1953.

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BLOOD BANKS

contract to the Red Cross in collecting blood for defense.

Then medical officers came back from the wars convinced of blood's value as a lifesaver in shock, accident and hemorrhage cases. They, too, pushed the development of blood banks in their home towns. The development, unfortunately, followed the patterns already laid down in their localities, so blood banks of all varieties mushroomed helter-skelter, each following its own methods of collecting and distributing blood.

An Urgent Appeal

The final contribution to the chaos came in 1947, when the Red Cross asked a commission of 50 prominent physicians to study the national blood bank situation. The doctors reported that many communities had little or no blood for civilian use—that thousands of Americans were dying unnecessarily each year for lack of blood. They urged the Red Cross to re-establish the blood-banking facilities it had operated so successfully during the war. The Red Cross agreed to go into the civilian blood business, but only in communities where no other adequate blood banks existed, and only where the local medical society approved.

On January 12, 1948, the Red Cross opened the first of 44 so-called Regional Blood Centers, each located in a major city but serving doctors and hospitals in a large sur-

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SHOULD BLOOD BANKS MAKE MONEY?

rounding area. That's when the howls began to go up from some of the private blood banks. For, though arrangements vary in different communities, the Red Cross insists on two basic principles: That blood be furnished only on a one-for-one replacement basis, and that the patient receive the blood without charge.

This is not "free" blood because the costs are borne by the American public through their regular contributions to the Red Cross. Nevertheless, some doctors running local blood banks sent up the cry of "socialism" and began their attempts to force the Red Cross out of the blood business. In most communities, however, there was harmony. There are places today where the program

is running so smoothly that doctors and lay people alike were amazed to learn from me that there is controversy and bitterness in other parts of the country.

Rochester, N. Y., for example, provides a picture of hope for the rest of the nation. In 1947, every hospital in Rochester had its own blood bank, but the blood was expensive and the supplies were limited. In the rural areas, there was virtually no blood at all. One of Rochester's distinguished physicians, Dr. Albert D. Kaiser, says, "I remember case after case where people died because the right kind of blood wasn't available at the right time. I particularly recall one woman in Albion, N. Y., who had se-

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Potassium Guaiaccol Sulfonate, N.F.	8 gr.
Sodium Citrate, U.S.P.	13.2 gr.
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Propenpyridamine Maleate	1 gr.
(10 mg./teasp., 5 cc. medicinal)	
Chloroform, U.S.P.	2 minims
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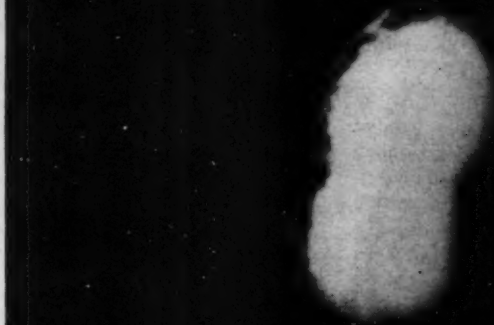


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ELECTRON PHOTOMICROGRAPH

Diplococcus pneumoniae 35,000 X

Diplococcus pneumoniae (*Streptococcus pneumoniae*) is a

Gram-positive organism commonly involved in

lobar—and bronchopneumonia • chronic bronchitis • mastoiditis
sinusitis • otitis media • and meningitis.

It is another of the more than 30 organisms susceptible to

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SHOULD BLOOD BANKS MAKE MONEY?

vere hemorrhaging one night in childbirth. They didn't have any blood available in the nearby hospitals. We had to send 40 miles for a technician to test the blood of donors, and we didn't get blood until 6:00 A.M. By that time it was too late. The woman had died."

In 1946, all the hospitals of the 12-county Rochester area banded together into a Regional Council and Dr. Kaiser was asked to investigate the medical needs of the group. He says, "Every hospital outside of Rochester itself told me, 'Give us blood. We can't afford to run blood banks or to hire technicians, but we need blood badly.'"

"Doctors returning from the service added to the clamor. Among

them was Dr. Herbert R. Brown, Jr., the Navy commander whose blood bank on Guam saved thousands of lives in the Iwo Jima and Okinawa invasions. He suggested the same kind of central blood bank that he had run in the Pacific.

"It was then that the Red Cross stepped in. They offered to finance and run a Regional Blood Center here, provided they got the concurrence of the local medical societies and hospitals. They got that concurrence. The co-operation was complete and none of us has regretted it since."

Today, the Regional Blood Center in Rochester serves 43 hospitals in an area of 5,000 square miles. Every person who lives in that area

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No allergic reactions to 'Ilotycin' have been reported in the literature. Staphylococcus enteritis, anorectal complications, moniliasis, and avitaminosis have not been encountered.

3 KILLS PATHOGENS

'Ilotycin' is bactericidal in generally prescribed dosages.

4 CHEMICALLY DIFFERENT

Virtually no gram-positive pathogens are inherently resistant to 'Ilotycin'—even when resistant to other antibiotics.

5 ACTS QUICKLY

Acute infections yield rapidly.

Available in tablets, pediatric suspension, and i.v. ampoules.

Average adult dose: 200 mg. every four to six hours.

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gets all the Red Cross blood he needs, without charge. The blood is provided by voluntary contributions of the citizens of the area and they have never failed to meet their quota.

How do Rochester's doctors and hospital officials feel about the Red Cross blood center? Dr. Frederick W. Bush, president of Rochester's Monroe County Medical Society, says, "In the light of its performance, how can I do anything but endorse the program as it operates here in Rochester?"

Joseph Henry, executive director of the Rochester Regional Hospital Council, told me, "The attitude of the hospitals is that the Red Cross blood center is the best thing to come down the pike."

Dr. Kaiser, who has held every position and won every honor in the local medical society, declared, "If we ever go back to the old commercial blood bank basis, the people would be furious and the doctors would suffer."

'It's Wonderful'

I spoke with Mrs. Dorothy White, a nurse who used to run the profitable private blood bank at Rochester General Hospital, and she said, "In the old days we had to keep searching for donors—often in the middle of the night. It was a difficult, nerve-racking business and I'm glad to be rid of it. The new system is wonderful. Now I just open the refrigerator. It is always kept stacked with all

possible blood types by the Red Cross."

The Rochester experience is not unusual. I heard similar stories at other Red Cross blood centers and in cities like San Francisco, Milwaukee and Minneapolis, where there are fine central blood banks that are run without profit by civic-minded residents of the community.

In many areas, however, the picture is not so bright. In Chicago, for example, there is no central blood bank and the Red Cross has not been allowed into the city by the medical society, except to collect defense blood in wartime. The local medical society feels that there is enough blood for civilians and that



"Psychology Magazine . . . Who do you think is calling, please?"

SHOULD BLOOD BANKS MAKE MONEY?

overcharges and other abuses are not their concern.

There are more than 50 private blood banks in Chicago, each operating in a different way. One of the main sources of supply is from the men along West Madison Street, Chicago's skid row. Fees to patients range from \$7.50 to \$100 a pint, with replacement rates varying from a one-pint-for-one to a four-pints-for-one basis. If a citizen of Chicago wants to contribute a pint of blood for defense today, he must travel 50 miles to one of the Bloodmobiles operating from the Red Cross Regional Blood Centers at Peoria, Ill. or Madison, Wis.

In Houston, so much rancor was stirred up by the fight between the

Red Cross and the Harris County Medical Society that the city lagged behind in blood collections for our troops in Korea and for civil defense. Houston's doctors abrogated their agreement with the Red Cross, charging (in addition to the "socialism" accusation) that the Red Cross was taking too much time to open its blood center. Instead, they signed a contract with Southwest Bloodbanks, Inc., which operates out of Phoenix, Ariz.

The executive director of Southwest Bloodbanks, Inc., is W. Quinn Jordan, a former worker in the Arizona State Welfare Department, who was appointed in 1946 to investigate the failing Salt River Valley Blood Bank, run by the Maricopa



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A gentle laxative modifier of milk. Just 1 or 2 tablespoonfuls in day's formula softens stools, usually overnight. Safe and easy to use.

GOOD FOR GRANDMA, TOO!

For thin, under-par older patients, acts as nutritional malt laxative. Softens stools without side effects by promoting aciduric flora. Grain extractives and potassium ions contribute to the gentle laxative effect. Dose: 2 Tbs. A.M. and bedtime for several days until stools are soft, then 1 or 2 Tbs. at bedtime to maintain regularity.

* Specially processed malt extract neutralized with potassium carbonate. In 8 oz. and .16 oz. bottles.

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ELECTRON PHOTOMICROGRAPH

Staphylococcus aureus 35,000 X

Staphylococcus aureus (*Micrococcus pyogenes* var. *aureus*) is a Gram-positive organism commonly involved in a great variety of pathologic conditions, including

pyoderma • abscesses • empyema • otitis • sinusitis
septicemia • bronchopneumonia • bronchiectasis
tracheobronchitis • and food poisoning.

It is another of the more than 30 organisms susceptible to

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SHOULD BLOOD BANKS MAKE MONEY?

County Medical Society in Phoenix. During his investigation, Jordan became so interested in the possibilities of blood-banking that he decided to take over management of the Salt River Valley establishment. In a short time, he had built up a thriving enterprise serving 4,000,000 people in eastern California, Arizona, southern Nevada, New Mexico, Texas, Louisiana and northern Mexico.

Mr. Jordan runs an efficient, ethical outfit, but it cannot live up to the A.M.A. principle against trafficking in human blood because it purchases much of its blood from down-and-outers and charges patients \$20 a pint if they do not replace on a two-pints-for-one basis. The Hou-

ston Post wrote that the Southwest bank is "merely a facility for the buying, processing and selling of blood"; and the ultraconservative Houston Chronicle declared that while most people are opposed to socialism, they also are tired of paying usurious prices for blood and that it would seem that the Southwest Bloodbank's rates are "still rather steep for persons of moderate means."

New York City has an equally confused situation. There are Red Cross blood centers in Manhattan, the Bronx and Brooklyn, but they do not provide coverage to everybody, as in Rochester. The local medical societies will permit them to collect blood only for defense, for the city

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Reference: 1. A.M.A. Exhibit, June 1951.

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All through his career, the doctor has financial problems that other business and professional men seldom face.

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How can the young doctor or intern with his modest income make certain that his family will be protected and that debts incurred in securing his training will be paid? No one knows better than the doctor that death and illness are constant hazards—and he has no company insurance or benefits to soften the blow.

AS HE BECOMES SUCCESSFUL...

When his practice is established, the doctor can count on a *peak* income for a far more limited number of years than his friends in the business world. And when his income is highest—so are his taxes—making it more difficult to save for the future.

AS HE APPROACHES OLD AGE...

At 55, 60 or 65, most of the doctor's business friends can count on comfortable retirement from company pension plans and Social Security—benefits not available to the doctor. In addition, his friends have had more opportunities to make carefully selected profitable investments.

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Through its 110 years of experience in serving doctors, Mutual Benefit Life has developed the "MD" Plan for doctors only.

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And because it is designed for you and you alone, you'll want the details directly from your own Mutual Benefit Life man. If you'll ask your nurse to drop us a line, we'll have him get in touch with you to arrange an interview that's mutually convenient.

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SHOULD BLOOD BANKS MAKE MONEY?

hospitals and for indigent city patients in private hospitals.

As an afterthought, the county societies also allowed the Red Cross to set up a "credit system," whereby employee groups and other organizations can contribute blood to the Red Cross, against which any member of the group can draw whenever blood is needed. Some of New York's private blood banks have credit systems, too, but they operate on a two-pints-for-one basis. In other words, you have to contribute two pints of blood in advance in order to get one when you need it. If you have no credits, you can be charged fantastic prices for blood in New York City.

The Blood Banks Association of

New York State, a voluntary clearinghouse for blood organizations, has become very sensitive about public reaction to charges of blood profiteering; recently it came up with a new "assurance plan." Under this plan, if you contribute one pint of blood, you or any member of your immediate family can each get four pints of blood for one year, if you need it. The trouble is that only a small percentage of the contributors will ever need it, and some probing New York newspapermen figured out that there was a mathematical certainty of a tremendous surplus, which could be sold by the blood banks at a profit of several million dollars.

When this aspect of the program

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was disclosed, Dr. William M. Markel of the Red Cross promptly resigned from the association's board of directors. In an exchange of letters with the association, Dr. David N. W. Grant, medical director of the American National Red Cross, wrote:

"As the program of the association developed, we have been concerned about some of the actions taken by it and its representatives. We are particularly concerned about the assurance program sponsored by the association that contemplates selling a large percentage of the blood collected, while nowhere in the brochure of the association is this fact given to the public."

But the antagonists in blood

feuds are not always the doctors and the Red Cross. Often the feuding involves doctors versus doctors, or doctors versus hospitals. In Miami, for example, some hospitals revolted against the excellent doctor-run Dade County Blood Bank in 1952 and established their own blood facilities.

Doctor Gives Reason

When asked for the reason, one of Miami's most prominent physicians told Miami Herald associate editor John Pennekamp, "The hospitals had to pay the blood bank each month for the blood they used. As the use of blood became more general, these checks became larger. So they decided to go into the blood

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BLOOD BANKS

bank business and thus retain for themselves some of the checks they were paying out."

What has been the reaction to such behavior? Some of it has been very costly for the nation. The federal government knows that vast quantities of blood plasma and blood derivatives must be stockpiled to save lives in the event of an atomic or H-bomb attack. Unless these blood products are available to fight shock and replace lost blood, millions of Americans will lose their lives during the first days of any new war.

Donations Fall Off

The Red Cross (with the help of a few private blood banks under contract to it) is the only agency authorized to collect blood for defense. The government reports that blood donations are falling off. Why? Partly, it seems certain, because many people think that *all* blood banks are operated by the Red Cross, and when they hear of unscrupulousness by private blood bank owners they think the Red Cross is trafficking in their blood. Nothing could be further from the truth, but several people told me they had stopped contributing blood for defense "because the Red Cross sells blood."

The Red Cross, on its part, is weary of the bickering and the innuendoes, and would, where feasible, like to have other organizations take over.

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Also offered under this plan is the Sanborn **METABULATOR**, a metabolism tester with many conveniences. Descriptive literature is available.

However, exclusive with Sanborn is a "direct-to-user" policy which offers any physician or hospital added benefits in ECG ownership. Among these is the opportunity to use a Viso Cardiette *as your own*, for 15 days, and without obligation of any kind. (If, at the end of the test period, you don't like the Viso, you simply return it to us in its convenient, specially designed shipping carton.)

Thus, to the usual aids in judging and selecting an ECG, Sanborn lets you add *your own experience*. May we tell you more about this plan?



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SHOULD BLOOD BANKS MAKE MONEY?

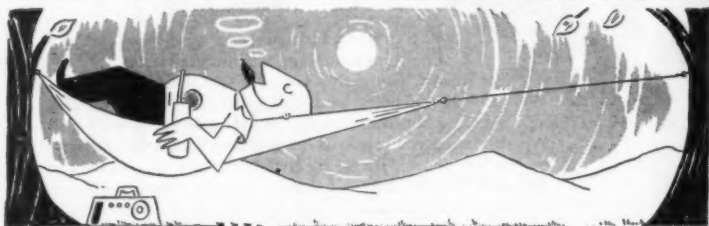
Even the most rabid opponents of the Red Cross agree, however, that no one else can muster the vast army of volunteers necessary to do the blood-recruiting job for a national emergency—or to supply civilian blood in widespread areas that can't possibly be covered by private blood banks.

Anirate Congressman

The wrangling and the profiteering and the skid row operations have not done the medical profession any good, either. There is a mounting tide of public indignation. Typical is the indignation of Republican Congressman Robert B. Chipfield of Illinois, whose wife was taken to a hospital in Chicago for an

operation which required many blood transfusions. The Chipfields are residents of the area covered by the Red Cross Regional Blood Center in Peoria, and so are entitled to Red Cross blood without charge. The hospital in Chicago accepted seven pints of the Red Cross blood to replace the seven pints administered to Mrs. Chipfield—but then they billed the congressman for seven pints more, at forty dollars a pint.

Representative Chipfield hit the ceiling. He wrote furious letters and spoke out against trafficking in blood. He considered blocking public grants to the hospital. The hospital eventually refunded his \$280. But think of the lasting bitterness



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'Thorazine' stopped hiccups (often after the first dose)
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Excerpts from two studies:

'Thorazine' stopped hiccups in 8 out of 10 patients. In 6 patients, "the hiccups were arrested within 20 minutes" after the first dose of 'Thorazine', in 2 other patients after the second dose. "Most of the commonly available remedies for hiccups had been tried before ['Thorazine'] was administered to these patients."

(Moyer et al.: Am. J. M. Sc. 228:174, Aug., 1954.)

'Thorazine' "stopped hiccup in five of seven patients treated and partially controlled it in the other two."

(Stewart and Redecker: California Med. 81:203, Sept., 1954.)

Available in 10 mg., 25 mg. and 50 mg. tablets; 25 mg. ampuls (1 cc.) and 50 mg. ampuls (2 cc.).

Smith, Kline & French Laboratories, Philadelphia 1

*Trademark for S.K.F.'s brand of chlorpromazine hydrochloride. Chemically it is 10-(3-dimethylaminopropyl)-2-chlorophenothiazine hydrochloride.

SHOULD BLOOD BANKS MAKE MONEY?

that similar actions have engendered in people who do not have the retaliatory power of a congressman.

The A.M.A. Plan

Is there any hope of ending the bitterness and making some order out of the blood bank chaos? Fortunately, some of our wiser medical heads have stepped in to end the confusion. In June, 1953, Dr. Robert Lee Dennis of San Jose, Calif., proposed to the House of Delegates of the A.M.A. "the establishment of a co-ordinated national blood bank program organized by the American Medical Association, the American National Red Cross and other qualified organizations interested in blood-banking."

The resolution passed, and led to meetings among representatives of the A.M.A., the Red Cross, the American Hospital Association, the American Association of Blood Banks and the American Society of Clinical Pathologists. A plan for a National Blood Foundation was agreed upon and approved in principle by all five organizations this year.

The goals of the foundation plan include: (1) free exchange of blood among all members on a one-unit-for-one basis, (2) elimination of profiteering, with only a service charge to the patient based on the actual costs of collecting, processing and distributing the blood and (3) a system of accreditation and in-

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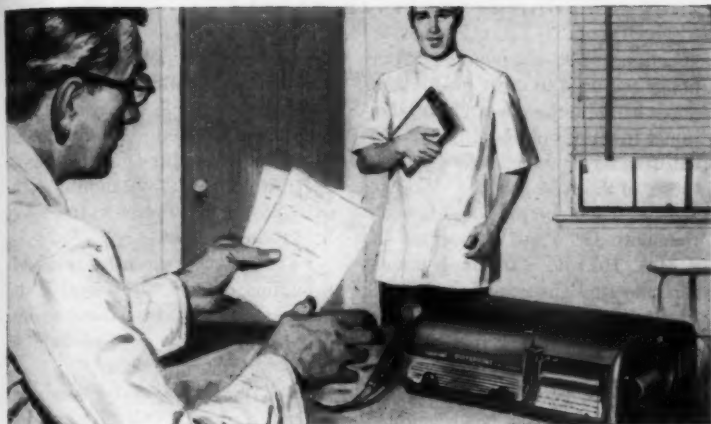
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SHOULD BLOOD BANKS MAKE MONEY?

spection, with all member blood banks required to meet health standards fixed by the government's National Institutes of Health, and ethical standards which are basically those of the A.M.A.

I discussed the proposed foundation with Dr. Paul Wermer of the A.M.A. He said: "It simply means that the Red Cross and the private blood banks can work side by side in a national network that will supply the needs of all the people. Since needs vary from community to community, the local medical, hospital and blood-banking groups will decide what type of banks they want, but for the first time there will be standardization through an all-important accreditation feature.

"We have no police power, but we'll rely on public co-operation. We'll make people aware that, for their own protection, they should insist on accredited blood banks only. In that way, we should eliminate most of the abuses in the blood field today.

"The A.M.A.'s essential interest is providing enough safe blood at the lowest possible cost to our patients. This plan is the best method of achieving that objective."

Will the new Blood Foundation become a reality? It's still touch and go whether it will. Only one thing is certain: if the plan doesn't go through, you and I and our children will be paying blood money for years to come.

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*Aaron, H.: Weight Control, Consumer Reports 17:100 (Feb.) 1962.



Chicago 11, Illinois

Jottings From A Doctor's Notebook

By Martin O. Gannett, M.D.

● Dr. Bernard Fuchs, he of the curly locks, the flamboyant eyebrows, and overbearing manner, was never the man to value his attentions cheaply.

"But, Dr. Fuchs," remonstrates Patient Yarrow, taken aback by the bill, "so much for seeing me at the hospital two weeks? You only drop in for a few minutes and tell a couple of stories. Your jokes are terrible."

"Quite right, my boy. All part of my plan of treatment. Those jokes I tell give you new will to get well so you can get away from here quickly. Saves you money in the end."

• • •

In the case of Gene Gessemer, the laboratory confused where it meant to clarify. The ascitic fluid was reported as containing: "Peritoneal implants, apparently from papillary cystadenoma of the ovary."

From the clinical standpoint, this didn't fit in with the hair on Gene's chest. And at laparotomy, only tuberculous peritonitis flourished where ovaries should have been.

• • •

After two patients in succession had died in N224, the room became the "funeral parlor," and no patient on N2 would stay in it. Each new admission was promptly appraised of the "hant" and it soon became evident that 224 was destined to become a linen room unless its reputation could be restored.

"Before we cut our capacity," suggested Superintendent Mellen, "why don't we plant some ambulant patient

now

the first oral liquid penicillin therapy...

with an antihistamine • enhanced by an antipyretic

CORICIDIN with Penicillin

(Soluble Powder)

all infections responsive to oral penicillin

- reduces risk of common sensitivity reactions
- controls fever



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CORICIDIN® with Penicillin
Soluble Powder, 60 cc.
bottles to which water
is added at the time
of dispensing.

Each teaspoonful (5 cc.)
of the prepared solution,
in a cherry-flavored liquid
that appeals to young
and old alike, contains:
Penicillin G Potassium / 250,000 units
CHLOR-TRIMETON® Maleate / 2 mg. (1/30 gr.)
Sodium Salicylate / 112.5 mg. (1 1/4 gr.)

and

prevent cold complications, relieve symptoms

CORICIDIN with Penicillin (tablets)

Bottles of 24 and 100.

150,000 UNITS

CORICIDIN

with Penicillin



about to be discharged in this room, let him stay two or three days, and break the jinx?"

So it was. John Lithberg, eight days post-herniorrhaphy and ambulant, became the new inmate of 224, after being transferred from the surgical ward. Early the following morning, when the nurse peeked in on her rounds, she found Mr. Lithberg peacefully dead in bed.

At autopsy, the pelvic phlebitis and massive pulmonary embolus provided sufficient explanation for the catastrophe. But just the same, nothing more mortal now dwells in 224 than towels and bed sheets.

That progressive specialization in medicine has caught on with the

public, can no longer be doubted:

Mrs. Schreiber, frantic with anxiety, bursts into the clinic, pulling after her a frightened and bawling four-year-old.

"Nurse!" she pants, "Where's the orthopedic doctor? Quick, show me to the bone specialist right away."

"But what's happened? Tell me what's wrong."

"Don't stand there; don't ask me. Please, before it's too late where's the orthopedic doctor? My Frankie just swallowed a fishbone."

• • •

On the far corner of the windowledge for the past two years, a robin family has been keeping house. For a week now, the nest has been home to four newly hatched fledglings—

TABLETS

Remanden.

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extends the scope of penicillin therapy

**GIVES BETTER PLASMA PENICILLIN LEVELS—
BOTH PEAK-WISE AND DURATION-WISE**

Clinical investigations now prove that when REMANDEN is administered the plasma penicillin levels are (1) comparable to those obtained with intramuscular peni-

cillin¹ and (2) superior to those obtained with other oral penicillin preparations.²



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References: 1. Antibiotics & Chemotherapy 2:55, 1952. 2. Scientific Exhibit, Norristown State Hospital. Data to be published.

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—are information and data to keep you posted on the latest developments in the detection and treatment of cancer.

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"Cancer—A Journal of the American Cancer Society"—a bimonthly devoted to articles, with bibliographies, by leading cancer authorities . . .

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Monograph Series—published about twice yearly, and focussed on the early recognition of cancers of specific body sites . . .

Item

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Item

"Cancer Current Literature"—an index to articles on neoplastic diseases from American and foreign journals . . .

Item

Professional Films—a series of 30 one-hour color kinescopes of television teaching conferences presented by leading clinicians in the cancer field; plus about 150 films on cancer diagnosis, detection and treatment, available on loan . . .

Item

Slide Sets—2x2 kodachrome slide sets dealing with early malignant lesions, available on loan.

for information about these
and other materials, write
your state Division of the

American Cancer Society



JOTTINGS FROM A DOCTOR'S NOTEBOOK

pulsing globules of protoplasm, all mouth.

Three of these, at the first chirp of mother, open their gullets to the sky for whatever may drop in. The fourth does not; at intervals the mother must peck baby's beak with her own, to induce it to open and receive some tidbit.

To pediatricians beset with the problem of babies who won't eat, I offer this avian neurosis as a consoling instance of the universality of the disease.

From the armchair Hippocrates:

I saw today one thing that distinguishes Interne Billings from his chief, Livingstone. The young fellow washes his hands carefully after

examining the patient, the older man before.

Not every charity patient accepts our city's tender mercies with equal grace. A particularly cynical beneficiary was Mrs. Nolti, a remarkably multiparous lady, whose last accouchement was attended at her home by Interne Clements.

Two days after the event, when Dr. Clements dropped in to see how the lady was getting on, he found her holding an ice bag to her bosom.

"Are you having trouble with your breasts?" he asked.

"Oh, no!" quoth the lady, with elaborate sarcasm. "No trouble. I only do this to keep the milk fresh."

END

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REG. U.S. PAT. OFF.
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Appreciated
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sick room

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Lavoris and its pleasant,
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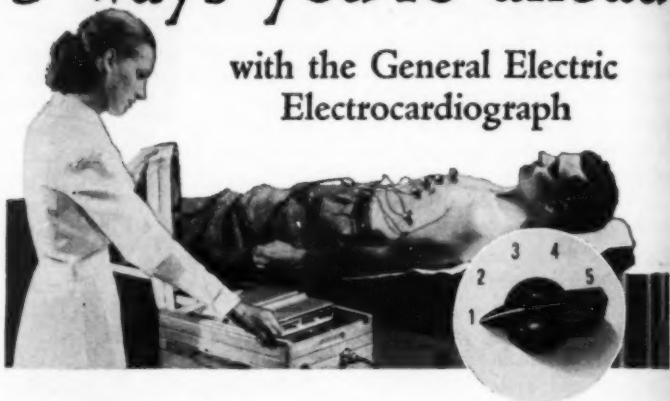
It's a new long-acting agent for the prevention and treatment of nausea and vomiting, associated with all forms of motion sickness, radiation therapy, vestibular and labyrinthine disturbances, and Ménière's syndrome.

Side effects, so often associated with the use of earlier remedies, are minimal with Bonamine. Its duration of action is so prolonged that often a single daily dose is sufficient. Bonamine is supplied in scored, tasteless 25 mg. tablets, boxes of eight individually foil-wrapped and bottles of 100.

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3 ways you're ahead

with the General Electric Electrocardiograph



① Exclusive switch selection for simpler, faster recordings

Without changing electrodes, you can take up to 30 leads, including six chest positions. Once the patient electrodes are in place, you can take leads 1, 2, 3, aVR, aVL, aVF, and the 1 to 6 positions at V, CR, CL and CF by merely turning selector switches.

② New paper drive for easier loading, greater accuracy

Using a new type of roller and a synchronous motor, General Electric assures uniform paper speed for accurate measurement of conduction times. Loading is simple — nothing to disassemble. Just flip open hinged door . . . place paper roll on spindle . . . thread through simple guides . . . and snap unit back in place. *All in a few seconds.*

③ New cabinet design for easier operation and carrying, added safety

Dual hinged covers open at a touch, making recessed controls immediately accessible. Cover supports no weight when unit is carried—handle attaches to main case. For all the facts on the DWB Cardioscribe, see your G-E x-ray representative. Or write X-Ray Dept., General Electric Co., Milwaukee 1, Wis., for Pub. C-125

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News

Tells patients what to look for in a

family doctor • M.D.s try out new international language •

Formula for office rents • Appeals expulsion from medical

society • Medical schools urged to speed up training

Urges Salaries for All Industrial Doctors

Most doctors who work for industry part-time apparently prefer to do so on a fee-for-service basis. But they ought to be on salary—for their own good as well as for the good of the company—maintains L. E. Newman, manager of health and safety services for the General Electric Company.

His argument: The fee-for-service man has no real stake in accident prevention or low employee turnover. Instead, his "compensation goes up in proportion to the plant's troubles": The higher the accident rate, the larger his fee; the greater the turnover, the more pre-employment physicals he gives.

This is bad for all concerned, says Newman. For one thing, he suggests, it's unreasonable: "Other members of management expect to be paid in proportion to the plant's successes rather than its failures. Then why not have the doctor paid on [the] basis . . . that the better in-

dustrial health he brings a business the higher his earnings? In other words, pay him better for his ounce of prevention than for his pound of cure."

The General Electric official insists that management wouldn't be the sole gainer under a blanket salary arrangement. "From the doctor's standpoint," he says, "the retainer fee, or salary, provides a dependable source of income." What's more, he adds, the salaried M.D. with most companies can take advantage of employee pension plans, special stock purchase plans, and low-cost group life insurance plans.

Cites G.P. Leadership In County Societies

G.P.s are playing an increasingly important role in the affairs of medical societies, notes Dr. Merlin L. Newkirk. "A few years ago most . . . societies were dominated by specialists," he says; but "since the formation of the [G.P.s'] Academy, general practitioners are showing a

in hypertension...

Rauwiloid

The ORIGINAL alseroxylon fraction of Rauwolfia

Serves Better

So Easy, too...

merely two 2 mg. tablets
at bedtime!

Because... *Rauwiloid is not the crude rauwolfia root.* Although Rauwiloid represents the total hypotensive activity of the pure whole Rauwolfia serpentina (Benth.) root, it is freed from the inert dross of the whole root and its undesirable substances such as yohimbine-type alkaloids.

Because... *Rauwiloid is not merely a single contained alkaloid of rauwolfia.* Reserpine—regardless of the brand name under which it is marketed—is only one of the desirable alkaloids in Rauwiloid, and therefore cannot provide the balanced action of the several alkaloids in Rauwiloid.

Because... *Rauwiloid contains, besides reserpine, other active alkaloids, such as rescinnamine,* reported to be more potent than reserpine.

Because... *Rauwiloid is the original alseroxydon fraction of unadulterated rauwolfia—rauwolfia in its optimal form—virtually no side actions—even fewer than other rauwolfia preparations—and there are no known contraindications. It rarely needs upward dosage adjustment.*

Riker

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much greater tendency to assume responsibility." As evidence, he points out that California alone has seventeen G.P.s. currently "serving as county society presidents."

Dr. Newkirk heads the California-Western Academy of General Practice; so he's naturally pleased with this changing state of affairs. In the academy's monthly bulletin, however, he warns his fellow G.P.s not to go overboard in supporting their colleagues for office:

"Too many times we have heard: 'I know Harry's not much good; but, after all, he's the only general practitioner running.' Voting for a general practitioner under these circumstances is a tragic mistake—first, because he won't be doing the best

possible job that could be done; and, second, because he may hurt the chances of a really qualified general practitioner getting elected to office in a following year."

Before supporting a man, he counsels, make sure that his qualifications are such that you would vote for him "even if he were a specialist."

One Way Out?

In answer to numerous complaints from patients, the British Medical Association is clamping down on doctors who maintain drab offices and drafty waiting rooms. It recently notified its membership of an impending inspection of all offices. If

NEW...SUSPENSION

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SIMPLE TO ADMINISTER—PLEASANT TO TAKE

REMANDEN can save you time and frequent house calls. You can use it to supplement your intramuscular injections, or it may be used alone. Patients take it gratefully, either as

Tablets of REMANDEN or as pleasant-tasting Suspension of REMANDEN.



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The High Protein Diet fits any budget!

Getting enough high-quality protein in your patient's diet need not be expensive. It is often a matter of reinforcing meat protein with other protein foods.

Mix a protein bonus in the main dishes—

Your patient can add skim milk powder to meat loaf—then hide hard-cooked eggs inside for a bright-eyed surprise.

An omelet folded over penny-sliced frankfurters, ground cooked meat, or flaked fish is both tempting and economical.

And a green salad can be topped generously with shoestrings of meat and cheese.

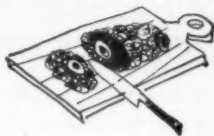
Then add more to the rest of the meal—

Cottage cheese is happily versatile. It tops any salad; makes a pleasing spread—especially on dark breads; or thinned with milk and mixed with chili sauce, it's a zesty salad dressing.

An egg white or gelatin whipped into fruit juice makes a frothy flip.

And a fruit-cheese dessert is a gourmet's delight. Pears with blue cheese, apples with Camembert, orange sections with cream or cottage cheese.

Of course, not all protein foods supply all the amino acids. But with sufficient variety, the diet is likely to supply all the essential ones, and at the same time assure adequate amounts of the vitamins necessary for proper protein metabolism.



United States Brewers Foundation

Beer—America's Beverage of Moderation

Protein 0.8 Gm., Calories 104/8 oz. glass*

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*Average of American beers

If you could "take apart"
a droplet of **KONDREMUL**
mineral oil emulsion...



...you would find it
different because

each microscopic oil globule is encased in a tough,
indigestible film of Irish moss for perfect
emulsification and complete mixing with the stool.

KONDREMUL[®] PLAIN

COLLOIDAL EMULSION OF MINERAL OIL AND IRISH MOSS

for chronic constipation

KONDREMUL Plain—containing 55%
mineral oil, bottles of 1 pt.

Also available: **KONDREMUL With
Cascara** (0.66 Gm. per tablespoon),
bottles of 14 fl. oz., **KONDREMUL
With Phenolphthalein** (0.13 Gm.
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highly penetrant...highly demulcent...
highly palatable—no danger of oil
leakage or interference with absorption
of nutrients when taken as directed

THE E. L. PATCH COMPANY
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any are found too cold or too dreary, warns the association, the offending M.D. will be subject to expulsion from the National Health Service.

Tells Patients How to Pick a Doctor

The layman in search of a family doctor will do better to go to a solo practitioner than to a large group clinic, advises *Changing Times*, The Kiplinger Magazine. Such clinics, it tells its readers, "have difficulty establishing close doctor-patient relationships in what may be an assembly-line atmosphere."

The magazine also urges the patient to:

¶ Collect as much personal data as possible about the prospective doctor. It may even be a good idea to find out "if there is derogatory information about [him] in the A.M.A. files."

¶ Try putting the chosen family physician through his paces by going to him for a thorough physical check-up. Notice whether or not he "leaps directly into an examination without taking time to talk to you and ask questions about you and your family . . . It is a good indication of his efficiency if he takes fairly copious notes . . ."

¶ Take a careful look around the doctor's office. "Clutter can be an indication of a disorderly, careless mind."

¶ Listen to the way the doctor talks: "If he boasts or runs down

other doctors, you can be pretty sure he is not your man."

¶ Ask him frankly about his fees. Medical men "are shy about bringing the matter up . . . and are usually happy if you will broach it."

¶ Pick a physician who's neither too old nor too young: "The best family doctor is a seasoned professional man who still has enough energy to read and study."

Mental Health Progress

Some convincing evidence that the nation is becoming increasingly conscious of mental health needs: Mental health expenditures by the forty-eight states now total \$560 million—a rise of some 300 per cent since 1944.

International Language Makes Medical Debut

New tongue is heavily based on Romance languages

Medical men are currently experimenting with a new medium of communication called Interlingua. Most recent of the century's 300-odd attempts to invent—and spread—an international language, Interlingua made its principal medical debut at the recent Second World Congress of Cardiology, in Washington, D.C. There, for the first time at a large international gathering, all medical abstracts were printed in the new tongue. [MORE→

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Brand of oxytetracycline

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Division, Chas. Pfizer & Co., Inc.

Few of the delegates had any prior knowledge of this composite language of the Western world; but most of them said they found it fairly easy to read. It seemed, they agreed, somewhat more practical than such of its knotty predecessors as Esperanto.

Interlingua is the product of twenty-seven years of linguistic research. Its vocabulary combines all the common elements of the modern Romance languages—chiefly Spanish, French, Italian, and Portuguese. For the doctor, who is generally pretty familiar with the Latin derivatives of technical terms, it's a particularly suitable international tongue. And, best of all, its grammar is extremely simple.

Here's a typical example of an Interlingual sentence in a medical paper:

"De tempore a tempore nos ha notate casos de chronic edemas cardiac que non respondeva a diureticos mercurial, a dietas a basse contento de natrium, a resinas a intercambio cationic, o a combinationes de istos."

And here it is in the original English:

"Occasional cases of chronic cardiac edema failed to respond to mercurial diuretics, low sodium diets, ion exchange resins, or combinations of these."

"Such easy-to-follow translations of scientific papers," says Dr. (of philosophy) Alexander Code, au-

TABLETS

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extends the scope of penicillin therapy

THE ORAL PENICILLIN OF CHOICE

REMANDEN is singularly effective in pneumococcal, staphylococcal, streptococcal and certain gonococcal infections and wherever secondary infection threatens. Valuable in rheumatic fever prophylaxis and in fulminating infections as an adjunct

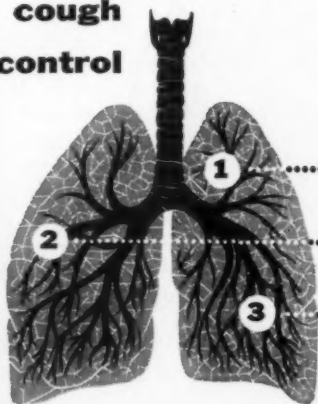
to parenteral penicillin. Sensitivity reactions by the oral route are fewer than with injected penicillin.



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3 way cough control



**Pyribenzamine Relieves
Congestion**

**Ephedrine Relaxes
Bronchioles**

**Ammonium Chloride
Liquefies Mucus**

Each 4-ml. teaspoonful of Pyribenzamine Expectorant with Ephedrine contains 30 mg. Pyribenzamine citrate (equivalent to 20 mg. Pyribenzamine hydrochloride), 10 mg. ephedrine sulfate, and 80 mg. ammonium chloride; cherry-flavored.

Also available: Pyribenzamine Expectorant with Codeine and Ephedrine (above formula plus 8 mg. codeine phosphate per 4-ml. teaspoonful); peach-flavored. Both preparations in pints and gallons.

Pyribenzamine® Expectorant

Pyribenzamine® (tripelennamine CIBA)

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*To relieve the itching of dermatosis
with greater safety from sensitization*

NEW TRONOTHANE®

HYDROCHLORIDE
(PRAMOXINE HYDROCHLORIDE, ABBOTT)

TRONOTHANE introduces a unique chemical structure into topical anesthesia. It is not a "caine," nor is it related to other anesthetics. Sensitization and toxicity can be expected to be negligible, judging from their absence in over 1,220 clinical trials to date.^{1,2,3,4}

Yet TRONOTHANE is prompt, effective. Use it to relieve discomfort in various itching dermatoses, anogenital pruritus, hemorrhoids, episiotomy, intubation, minor burns, etc. **Abbott**

CREAM



FERILE JELLY



COMPOUND LOTION



OPICAL SOLUTION



1. White, C. J., A New Anesthetic for Certain Diseases of the Skin, *J. Lancet*, 74:98, March, 1954.
2. Schwartz, F. R., Tronothane in Common Pruritic Syndromes, *Postgrad. Med.*, 16:19, July, 1954.
3. Birnberg, C., and Horner, H., A Simple Method for the Relief of Postpartum Perineal Pain, *Amer. J. Obst. & Gynec.*, 67:661, March, 1954.
4. Peal, L., and Karp, M., A New Surface Anesthetic Agent: Tronothane, *Anesthesiology*, in press, 1954.

thor of the 27,000-word Interlingua dictionary, "should certainly improve international give-and-take of ideas in spheres where it really matters."

To lend weight to this point of view, some medical and scientific journals are already experimenting with the new language. There are two all-Interlingua publications: *Spectroscopia Molecular*, published by the Illinois Institute of Technology, and *Scientia International*, an international version of *Science News Letter*. Interlingua summaries of English-written articles have become routine in three other U.S. periodicals: *Blood*, *The Journal of Hematology*; *The Journal of Dental Medicine*; and *The American Journal of Psychotherapy*.

Such abstracts, according to one enthusiast, "make the material available to all readers without the necessity of costly multiple translation into various languages."

Works Out Formula for Setting Office Rents

How can you determine an equitable rent for professional office space? There's no hard-and-fast rule, of course. But John C. Post, a professional management consultant in Washington, D.C., has devised a formula that he feels is widely applicable.

Suppose, for example, that a building cost \$60,000, and that the lot it stands on cost \$10,000. As-

sume that the owner has invested \$20,000 cash in the property and that he has a mortgage of \$50,000 at 4½ per cent. Suppose, finally, that he plans to use half the building himself and to rent out the other half.

Here, according to Mr. Post, is the way to arrive at a fair rental:

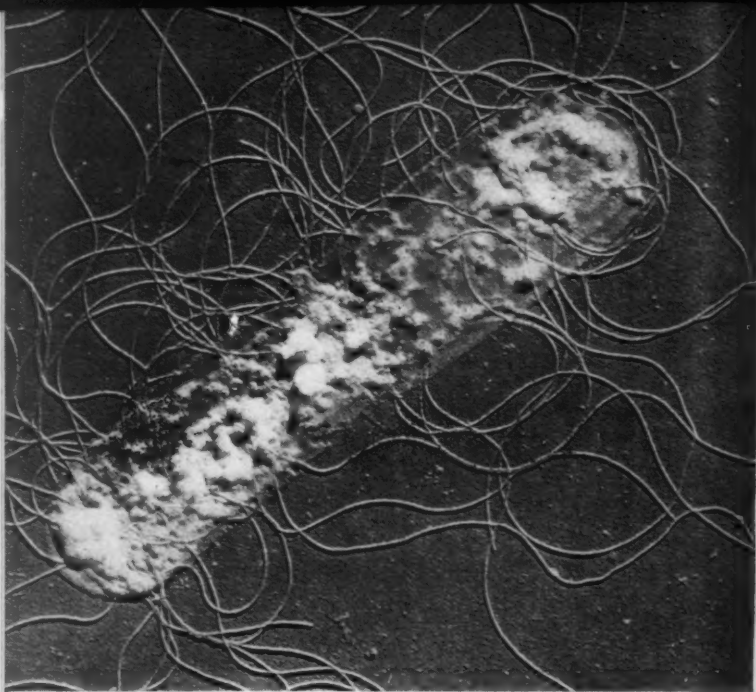
5 per cent of <i>half</i> the cash investment	\$ 500
<i>Plus</i>	
4½ per cent of <i>half</i> the mortgage	1,125
<i>Plus</i>	
Depreciation allowance of 3 per cent on <i>half</i> the building	900
<i>Plus</i>	
<i>Half</i> the cost of utilities, repairs, taxes, insurance, and maintenance—for example	1,200
Yearly rental...	\$3,725

Obviously, the figures for *your* building will be different. But, says Mr. Post, the formula should hold true under almost any circumstance.

Doctor Fights Expulsion On Slander Charge

He loses suit for reinstatement; appeal pending

Most doctors make it a rule not to criticize their colleagues. But in early 1952, Dr. Samuel L. Bernstein of Pittsburg, Calif., was expelled by



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Proteus vulgaris 20,000 X

Proteus vulgaris is a Gram-negative organism commonly involved in
 urinary tract infections • septicemia • and in peritonitis
 following low perforation of the gut.

It is another of the more than 30 organisms susceptible to

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100 mg. and 250 mg. capsules

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NEWS

the Alameda-Contra Costa Medical Association for alleged critical remarks about fellow members. And despite a hard-fought battle that eventually led to court action, he had still failed to gain reinstatement as 1954 drew to a close.

Here are the circumstances of the case, as reported to doctors in the Alameda area by Alan L. Bonnington, one of the attorneys for the medical society:

Back in 1951, the association received "various complaints against Dr. Bernstein by other members." But no formal charges were filed for almost a year. In the meantime, "the Ethics Committee tried to resolve the difficulties by investigating the various claims and discussing them with Dr. Bernstein." Only when this proved of no avail, says Bonnington, was the case brought before the society's council.

The council found Bernstein guilty of unprofessional conduct and voted to expel him from the society. Among the reported incidents that led it to take this step:

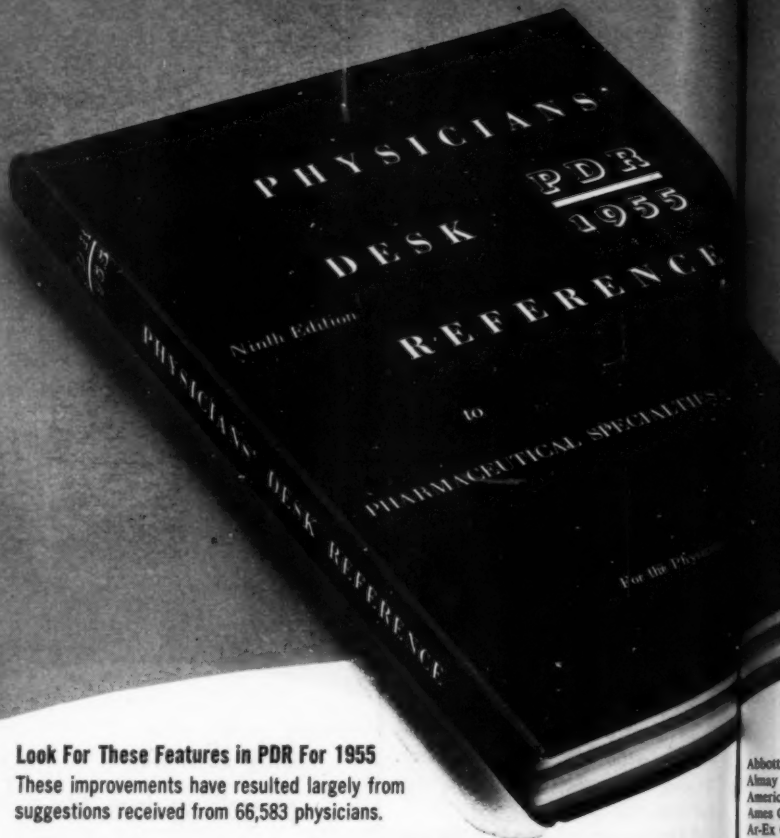
¶ On one occasion, when the parents of a young patient spoke of consulting another doctor, Dr. Bernstein reportedly "flew into a rage, referred to the other doctor as a 'butcher,' and ordered the people out of his office."

¶ In reviewing a colleague's autopsy report for the Industrial Accident Commission, Bernstein, it is said, "frequently referred to the other doctor as an inept and inex-



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more complete, 1955
edition of "one of the best
friends a memory
ever had" . . .





Look For These Features in PDR For 1955

These improvements have resulted largely from suggestions received from 66,583 physicians.

Larger Professional Products Information Section (White) now contains 1700 specialties.

More complete information about specialties, including composition, administration, dosage, "how supplied".

Simplified, phonetic spelling of complex specialty names.

Restyled key pages for ease-of-reference.

New Therapeutic Indications headings (Blue Section) to conform to present usage.

Comprehensive Alphabetical Index (Pink Section) now includes every important ethical specialty made by leading pharmaceutical manufacturers.

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will soon be off the press

Medical Economics, Inc., is pleased to make available this improved and more complete reference volume of leading ethical specialties in cooperation with the 145 leading pharmaceutical manufacturers listed below:

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[Within the hearing of a woman who was about to undergo a Caesarean section for the birth of her second child, Dr. Bernstein allegedly told an attending nurse "that the [operation] was 'uncalled for . . . silly . . . foolish,' that if she had 'pushed one through,' she could certainly 'push a second through,' and that this was the 'poorest excuse for a section' that he had ever seen."

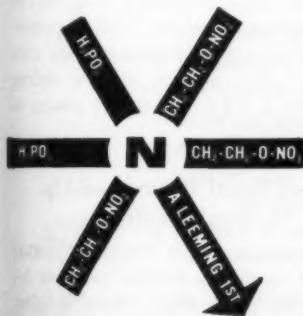
[He reportedly gave the brother of one of his patients "an unqualified and disparaging opinion concerning the past and proposed orthopedic procedures" of another doctor in the area.

Dr. Bernstein promptly appealed

the council's adverse decision. But both the state medical society and the A.M.A. Judicial Council agreed that his expulsion from the county society was justified. So Dr. Bernstein next filed for a writ "to compel the Association to readmit him to membership." In a fourteen-page petition, he charged (among other things):

That the accusations against him had been part of a "conspiracy . . . to impose censorship upon him"; that he had been unfairly tried and "wrongfully expelled"; that the "Principles of Medical Ethics violated public policy and were illegal"; and that "as the result of his unlawful expulsion he had been damaged . . . personally, profession-

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ally, and economically . . . in the sum of \$100,000."

Early in 1954, the case was tried in the Superior Court of Martinez, Calif. Once again the action of the Alameda-Contra Costa Medical Association was sustained. Chief contention of the lawyers for the medical society, on which Judge Norman A. Gregg based his ruling: "... the conduct of Dr. Bernstein did not involve merely a dispute between doctors, but rather one where the health . . . of the patients involved very easily could have been affected."

Dr. Bernstein still hasn't given up. He has filed yet another appeal with a higher court.

Turnabout's Fair Play

Wisconsin pharmacists have launched an intensive state-wide newspaper-ad campaign against doctors who dispense drugs—and they're adapting one of the medical profession's favorite slogans to their own use: The patient, they're telling readers, is entitled to free choice of pharmacist.

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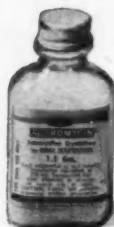
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NEWS

whole process can—and should—be speeded up, says Dr. Wilburt C. Davison of Durham, N.C. How? Like this:

1. By "overhauling premedical education" so that students will be ready to enter medical school after only two or three years of college. (To bring this about, Dr. Davison urges that medical schools be allowed to exercise much greater control than they now do over the premedical curriculum.)

2. By putting students through medical school on an "accelerated schedule." To show that such a system can work, Dr. Davison cites the twenty-four-year-old program of the Duke University medical school (of which he is dean): "Seventy-six per cent of the Duke students are graduated in less than four calendar years . . . by condensing the four medical school years of thirty-three weeks into three years of forty-four weeks each."

The speed-up system has obvious advantages, says Dr. Davison:

¶ The student will be "one year younger at graduation and will have an additional year for hospital or other training";

¶ He will be "better prepared" by virtue of not losing "a fortnight or a month in October of each year getting back into the intellectual stride"; and

¶ By remaining at school during part of the summer, he'll have a chance to see "clinical material peculiar to the summer months."

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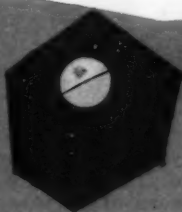
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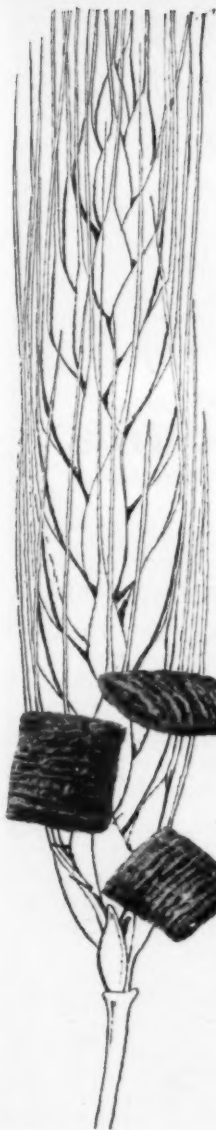


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Memo

FROM THE PUBLISHER

There's a Limit

How far can a magazine go in giving specific advice on such subjects as investments, insurance, taxes, and business management?

This is a recurring question for MEDICAL ECONOMICS. Our main aim, after all, is helpfulness. We want to go as far as we can to help you and the rest of our 134,000 physician-readers. But if we go *too* far—if we get too complicated or detailed—we may lose the majority's interest and thus actually defeat our main purpose.

We learned this lesson some years ago, through a series on estate planning. We published a full dozen articles on the subject, and they were authoritative and important. But the simplest possible presentation couldn't disguise the fact that the subject was enormously complex. Looking back on the series, we're inclined to think that only a minority of readers stuck with it to the end. Since that time, we've generally stopped short of covering a complex subject in full detail.

Some doctors apparently assume otherwise. "That's my bible," they're reported to say of the magazine; and they allegedly resist all personal

counsel that deviates from our published advice.

While we're naturally pleased to hear about such reader loyalty, we wonder whether these doctors fully understand the limits of our advice. Consider, for example, three articles in this issue:

¶ "How to Sell a Practice" goes into detail about a typical practice sale. But it doesn't take up atypical details that might just happen to fit *your* practice. That's why you still need personal guidance before buying or selling.

¶ "Here Are the Practice Costs You Can Tax-Deduct" lists all major professional deductions allowed by Internal Revenue. It doesn't list certain minor deductions that, in your special case, might produce tax savings. Only a tax consultant can help you find all the savings you're entitled to.

¶ "Things to Know About Investment Funds" reports the recent performance of many leading companies. But recent performance isn't the whole story; nor are the companies named here necessarily the best ones for you. It wouldn't be wise to invest your money on the strength of this article alone.

Do these words of caution seem superfluous to you? Then you're probably using MEDICAL ECONOMICS as it's designed to be used: as a source book of useful business ideas; as a stimulating supplement to personal counsel; *not* as a substitute for such counsel. —LANSING CHAPMAN

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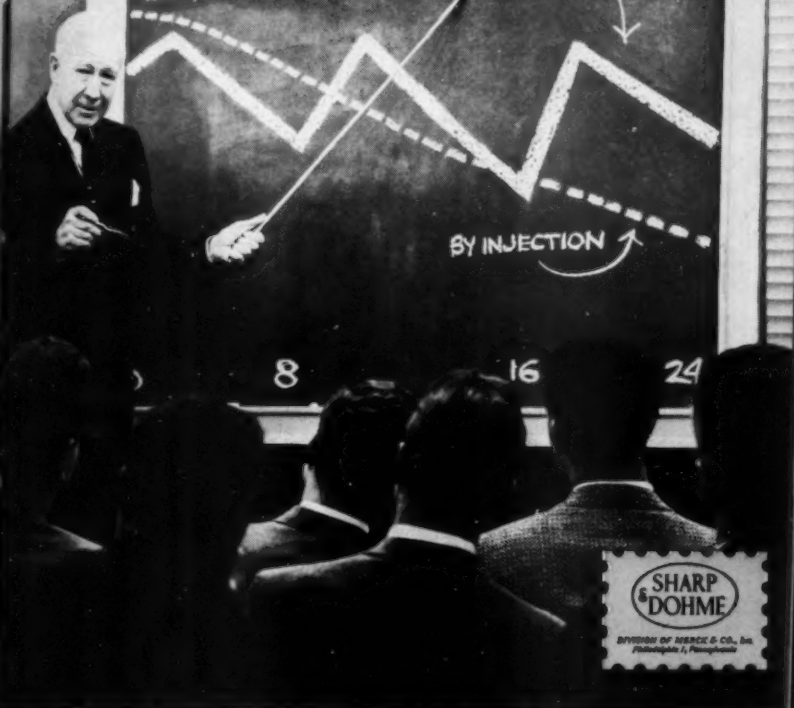
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Write, on your prescription blank, to IVORY SOAP, Dept. C, Box 687, Cincinnati 1, Ohio

*Ask for the Handy Pads you want by number.
No cost or obligation.*



99⁴⁴/100% Pure • It Floats

- No. 1: "Instructions for Routine Care of Acne."
- No. 2: "Instructions for Bathing a Patient in Bed."
- No. 3: "Instructions for Bathing Your Baby."
- No. 4: "The Hygiene of Pregnancy."
- No. 5: "Home Care of the Bedfast Patient."
- No. 6: "Sick Room Precautions to Prevent the Spread of Communicable Disease."